Medicare Contractors' Conference Report

March 10-11, 1980

U.S. Department of Health and Human Services
Health Care Financing Administration

Information Resource Center

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THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) was established to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries - approximately 47 million of the nation's aged, disabled and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

THE MEDICAID/MEDICARE MANAGEMENT INSTITUTE (M/MMI), within the Health Care Financing Administration, Bureau of Program Operations, works with Federal, State, and contractor staff toward improved management of the Medicaid and Medicare programs.

The M/MMI promotes program management improvements through problem analysis and technical assistance for corrective action, and fosters exchange of ideas and techniques through conferences, workshops, training and publications.

MEDICARE CONTRACTORS' CONFERENCE REPORT

DALLAS, TEXAS

March 10-11, 1980

Medicaid/Medicare Management Institute

Health Care Financing Administration
Department of Health and Human Services

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PREFACE

Held in Dallas March 10-11, 1980, the first annual Medicare contractors' conference provided a forum for exchange of information and concerns between the Medicare contractor community and HCFA senior staff. Among the highlights of the conference were: presentations by HCFA Administrator Leonard D. Schaeffer on HCFA's plans for improving health care information systems and the program operating framework; and HHS Under Secretary, Nathan Stark's speech "Health Care in the 1980's."

Panels of contractor executives and HCFA senior staff addressed program initiatives, issues and techniques relating to competitive procurement of Medicare contracts, evaluating the quality of health care and contractor performance, and improving services to beneficiaries. Four discussion papers were distributed which provide an overview of major HCFA initiatives impacting Medicare management; a policy statement on the Annual Hospital Report, and three discussion papers on Health Care Information Systems of the 1980's, the Operating Framework for HCFA Program Administration, and HCFA Goals for Improving Consistency, Accuracy and Comparability of Diagnosis and Procedure Labeling Systems. Copies of these papers may be found in the appendix of this report.

Approximately 250 people registered for the conference, including about 175 contractor executives, with 49 States and Puerto Rico represented. Other attendees included four State representatives, a consumer representative, Medicare subcontractor executives, HCFA staff and a member of the President's Management Improvement Council.

SUMMARIZED AGENDA

PRESENTATION	SPEAKERS
WELCOME AND CONFERENCE OBJECTIVES	MARY KENESSON Director, M/MMI HCFA/Bureau of Program Operations Baltimore, MD JIM MERRYMAN Regional Medicare Director Dallas, TX PAUL WILLGING Deputy Director, BPO HCFA Baltimore, MD
KEYNOTE ADDRESS	
"HCFA Contracting Strategies"	LEONARD D. SCHAEFFER Administrator HCFA Baltimore, MD
IMPACT OF THE HCFA CONTRACTING STRATEGIES ON MEDICARE CONTRACTORS	Moderator: MILDRED L. TYSSOWSKI Director, BPO HCFA Baltimore, MD
	Resources: EARL M. COLLIER Deputy Administrator HCFA Baltimore, MD
	LESTER M. ALBERTHAL Vice President E.D.S. Federal Corp. Dallas, TX
	JOHN E. BUELT Vice President President's Management Improvement Council St. Louis, MO
	JOHN L. THOMPSON President Blue Cross/Blue Shield of Massachusetts Boston, MA

SUMMARIZED AGENDA

PRESENTATION	SPEAKERS
HEALTH CARE IN THE 1980's Remarks	NATHAN STARK Under Secretary HHS Washington, DC
HEALTH CARE IN THE 1980's	Moderator: PETER FOX Director, Office of Policy Analysis HCFA/Office of Legislation and Policy Washington, DC
	Resources: EARL M. COLLIER
	LOUIS A. ORSINI Vice President Health Insurance Association of America New York, NY
	EDWIN R. WERNER President Blue Cross/Blue Shield of Greater New York New York, NY
NEW DIRECTIONS IN QUALITY OF OPERATIONS	Moderator: FREDERICK J. MALLEY, Jr. Vice President The Equitable Life Assurance Society of the U. S. New York, NY
	Resources: JOHN JANSAK Director, Office of Standards and Performance Evaluation HCFA/BPO Baltimore, MD
	JOHN BERRY Director, Office of Quality Control Programs HCFA/Bureau of Quality Control Baltimore, MD
	DON NICHOLSON Director, Office of Program Validation HCFA/BQC Baltimore, MD

SUMMARIZED AGENDA

PRESENTATION	SPEAKERS
NEW DIRECTIONS IN QUALITY OF OPERATIONS (continued)	ROBERT E. RINEHIMER President Pennsylvania Blue Shield Camp Hill, PA KEN SCHNEIDER Regional Director HCFA/Health Standards and Quality Bureau Dallas, TX WILLIAM C. WHITE, Jr. Vice President The Prudential Insurance Company of America Millville, NJ
PROGRAM INITIATIVES FOR IMPROVING SERVICES TO BENEFICIARIES	Moderator: LINDSAY HANNA Director of Government Programs Connecticut General Life Insurance Company Bloomfield, CT Resources: DON SLOO Vice President Blue Cross/Blue Shield Government Programs Mutual Hospital Insurance, Inc. Indianapolis, IN PETER D. MILLS Second Vice President and Chief Medicare Administrator Occidental Life Insurance Company of California Los Angeles, CA BARNEY SELLERS Director, Office of Beneficiary Services HCFA Baltimore, MD MILDRED L. TYSSOWSKI DOROTHY RYAN National Council of Senior Citizens Youngstown, OH

SUMMARIZED AGENDA

PRESENTATION	SPEAKERS
PROGRAM INITIATIVES FOR IMPROVED SERVICES TO BENEFICIARIES (continued)	PAT SCHOENI Director, Office of Public Affairs HCFA Baltimore, MD
CLOSING REMARKS	CHARLES W. STEWART Executive Vice President California Physicians Service San Francisco, CA EARL M. COLLIER

KEYNOTE ADDRESS

HCFA CONTRACTING STRATEGIES

LEONARD D. SCHAEFFER

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

The health care industry is now the third largest in the country. The availability of health insurance -- both publicly and privately funded -- has contributed significantly to this growth, and today millions of Americans have access to health care benefits they would not otherwise enjoy. Your involvement in the nation's health care system has been vital to its success. We recognize the value of your partnership role in our publicly funded health care programs, and we share with you a number of common interests and concerns.

Many of you present here today were involved in the pioneering efforts which established the Medicare program, and we recognize our indebtedness to you. It has been four years since the last national conference for Medicare contractors. This type of conference provides a good forum for exchanging viewpoints and experiences, and we plan to begin a series of annual meetings such as this one.

The Surgeon General recently reported that the American people have never been healthier. They live longer. Infant mortality has decreased. Fewer Americans under forty-five die of cancer. The growth of the health care industry has brought us new standards in quality health care. Our medical technology holds the promise of even greater achievement in the next decade.

The issue facing our country then is not whether we can provide quality care, but how to finance that care. Health care expenditures in the U. S. are almost $200 billion annually. This year, HCFA will spend about $47 billion bringing Medicare and Medicaid benefits to 47 million beneficiaries. In 1981, that figure will increase to $53 billion.

HCFA's programs have become the largest single purchaser of health care in the nation. We pay 25% of all the health expenditures in this country and 40% of acute, community hospital care.

Our mission in HCFA is threefold:

- To promote the timely, cost effective delivery of appropriate, quality health care services to our beneficiaries.

- To make beneficiaries aware of the services for which they are eligible, and to make those services accessible to them in the most effective manner.

- To ensure that our policies and actions promote efficiency and quality within the total health delivery system which serves all Americans. This requires a constructive relationship with providers and third parties involved in that system.

This meeting is an example of how we intend to pursue the third part of our mission. We want to work with you to make improvements in our operations in a manner that will have a positive effect on both your public and private lines of business. Our goal is to help make the entire system more effective in serving both our beneficiaries and the general public.

As we try to meet the nation's expectations for access to quality care, there is even greater demand for increased public spending to bring these benefits to the aged, poor and disabled - those in our population who are among the most vulnerable in our society. Our job in HCFA is to use the money available to meet our beneficiaries' needs in a manner that encourages both an efficient and effective health care system. That system must be efficient in terms of providing appropriate and necessary services at a reasonable cost, and effective in terms of the quality and timeliness of the care delivered to those people needing the service.

In HCFA we have three basic functions: We establish policy and write regulations, we enter into agreements with States and contracts with fiscal agents to operate our programs, and we monitor the performance of States, contractors and individual providers. We do not see an increasing role for HCFA in the direct operation of our programs. We do not want to take on - and could not take on - your responsibilities or those of the States with regard to Medicare and Medicaid.

HCFA's basic responsibility is to use financing mechanisms to make health care services available to our beneficiaries. To do that in a time of extremely limited resources, we have to make more prudent management decisions which will in turn make better use of our limited dollars.

For our dollars are truly limited. Health costs are escalating, and the financers of health care -- both public and private -- are running out of money. Productivity in this country is declining and thus real government revenues are not increasing in a time of inflation and competing demands. Private insurers are meeting increasing resistance to premium increases from their policyholders.

In order to improve the management of our programs, we in HCFA must strive for changes in three areas:

- We must find ways to simplify our programs -- make them more understandable to both the providers and the beneficiaries.

- We need to take steps to make Medicare and Medicaid more consistent with each other. While they are different programs with different beneficiary populations and eligibility requirements, they are functionally similar. We want to make them administratively more consistent in order to make it easier for providers and contractors to do business with us, and thereby improve access to care and services for our beneficiaries.

- We must make changes in our methods of operation which help bring about improvements in the practices of the rest of the insurance industry and in the total health care system.

We intend to continue our policy of contracting with others to operate our programs. Therefore, we do and will continue to rely on you. We are here today to discuss the nature of that reliance and of our relationship.

Medicare could not have gotten off the ground in 1965 without the help of many of you who served as carriers and intermediaries in the early years. But the program has grown substantially, from $3 billion in 1967 to almost $34 billion in 1980, and has become infinitely more complex and demanding upon all of us.

As our financial and programmatic responsibilities grow, I believe that our relationship and mutual obligations must become more explicit and more rigorous. You must know what we expect and vice versa. We must be able to work cooperatively as we proceed in a common direction.

There are two specific areas I would like to discuss with you this morning -- health information systems for the 1980's and the operating framework for HCFA programs. We have prepared discussion papers on these two issues which are available here today. We want to consult with the industry on these issues and view this conference as a beginning of that dialogue.

Health Care Information Systems in the 1980's

When government financing of health care began, Medicare program operations were patterned after the systems used by health care insurers of the day and the existing approaches and tools were adopted for the public programs.

As the business of providing and financing health care to the nation evolved, programs were added, requirements were changed and both the public and private sectors refined their operations to meet their own growing needs and responsibilities, without much concern for how the behavior of one company or program affected the others. In fact, the impact on the industry of such changes was relatively insignificant at the time because there was little or no crossover activity or comparability of needs.

But as the industry expanded so did data and information handling systems. Those systems have met, and many may continue to meet, the individual needs of users. However, overall the systems we use to process and pay claims are incompatible. This confounds communication, contributes to inefficiencies and inflation, and makes it extremely difficult to aggregate and analyze data. Today's health care financing systems -- and I am referring to operating not reimbursement systems -- have evolved into what is really a nonsystem that is not capable of dealing comprehensively with the incredibly complex business of funding our nation's health care needs. Our systems needs have clearly changed. As we look toward the requirements of the 1980's, we must build new systems that can reduce redundancy and improve the timeliness, accuracy, and efficiency of the health care financing process.

We intend to examine this existing nonsystem alongside the anticipated demands of the future. In doing this, we want to collaborate with the industry in developing and implementing a process for simplifying and unifying our health financing and information systems throughout the industry. The result should be a reduction in the present reporting burden on all providers, more accurate and timely reimbursement, and better information for health care managers and planners at all levels.

We must establish common tools and instruments for communicating among the users and between providers and users. We must promote cost effective alternative systems for capturing and disseminating data to multiple users.

To achieve these goals, HCFA is committed to working with the private sector to bring about major improvements in the management of health financing systems in the 1980's. An example of how, together, we can work toward these ends is the process used in developing a common procedure labelling system. You recently received copies of a HCFA discussion paper on that subject. We have arrived at the position presented in the discussion paper only after intensive consultation with the private sector, particularly those most affected. The paper lays out our direction for the future, but we encourage you and other interested parties to advise us and participate with us in decisions regarding the implementation of the policy decision. We will be very flexible in terms of timing and specific implementation steps, but we will use all of HCFA's financing authorities to support our basic direction and will not fund incompatible systems in any of our programs.

For this conference, we have prepared another HCFA discussion paper on the subject of Health Financing Systems of the 1980's. I would like to have your comments on the issues presented in the paper, which I must stress, is only a discussion draft. However, I would like to mention briefly some of the areas of particular concern.

One focus will be on establishing common grounds for communication through implementing common coding, definitions, identifiers and data sets all designed to meet the needs of and facilitate communication among multiple users. Working together and coordinating our activities in this important area, we can realize immediate improvements in accuracy, timeliness, reduced costs, and significant reduction in the reporting requirements for providers. This can form the base for further improvements.

We are testing various models of linking and transmitting hospital billing and discharge information. The basic model integrates and automates the patient bill and discharge data at the hospital. The provider can then transmit the data to a central clearinghouse which will reformat the data and forward it to the users. As an alternative, the provider may transmit the information directly to the users. Users of data include third party payors, PSROs, State and local health planners, as well as State rate setting agencies.

These demonstrations shall prove that the development of consistent definitions, and the use of integrated, automated systems provides advantages for all participants. For example, providers can expect more accurate reimbursement and more timely turn around which will improve their cash flow and at the same time provide a significant reduction in redundant recording and reporting. Users may expect to receive data ready for their immediate use, in addition to it being more accurate and timely.

This more comprehensive approach to gathering information on health care financing activities will mean a corresponding reduction in the number of expensive data collection and processing systems and the number of personnel required to enter and correct data. Simply converting the transmission of paper documents from providers to fiscal agents to a process that involves computer to computer communication will substantially reduce the labor content involved in redundant data entry, and thus reduce cost and speed up processing.

Operational Framework for HCFA Programs

There have been significant changes in Medicare and Medicaid program administration over the years with respect to technology, organization and program acceptance. The initial administrative structure served well the original needs of the programs. Reliance on the private sector contractors has been quite successful in the administration of both programs and there is no demonstrated need for changing those relationships.

However, in Medicare the intense pressure of the growing workloads, the increasing complexities in policy and procedures, the new initiatives to contain health care costs, all have created a current environment that demands a new look at the administrative structure. We need to establish a framework of operations that will simplify our process and procedures, improve the timeliness and the accuracy of program payments, improve the quality of service to providers and beneficiaries and result in a better understanding and more uniform application of program policy. In short, we need an operational framework which will more effectively serve program needs in the 1980's and future years.

In looking to the future, we need to address the desirability of combining the administration of Medicare Part A and Medicare Part B into a single contractor structure. The initial separation of Part A and B was a result of the legislative development of the Medicare program. It is unlikely such a split would occur if the law were written today. There are many crossovers between the two parts of the program.

Combining them under a single contractor for a defined geographic area should reduce administrative costs, provide for better utilization review and control of program payments, and simplify beneficiary access to the understanding of the Medicare program. It also should improve the exchange of data with PSRO, Medicaid and other agencies, public and private, with a legitimate interest in program information.

Another major aspect of our Medicare contracting that must be addressed is the lack of competition in the entire process. In our fiscal year 1981 budget, an estimated $719.6 million will be spent on Medicare contracts. Except for funding a few experimental contracts which were awarded competitively, this money will be spent on negotiated contracts, with the contractors being reimbursed on a cost basis. No other program in the Federal government has such a high dollar volume of contracts awarded on a noncompetitive basis.

These and other issues relating to Medicare contracting have been addressed in three studies. In 1978, an internal HEW study was carried out which concluded that Parts A and B administration should be combined into a single administration. Contracts should be let competitively, and contractors should be reimbursed on other than a cost basis. An independent study conducted by the General Accounting Office for Congress in 1979 supported many of these conclusions.

The President's Management Improvement Council was established in 1979 to provide advice on ways to improve the management of Federal programs. One of

its first steps was to create a Subcommittee on Health Care Costs which undertook as one of its first assignments a review of our contracting procedures in Medicare. The Subcommittee's recommendations, as reflected in their draft report, support the selecting of contractors on a competitive basis, reduction in the overall number of contractor geographic areas based on optimum workloads.

Changes to the operational framework of HCFA programs will take place over the next decade and will be consistent with a national health plan. These changes will focus on four basic objectives:

1. Establishing specific standards of performance in contracts. These standards would serve as a basis for assessing financial damages or taking adverse contract action with respect to poor performance. They will also be the basis for incentive payments for superior performance.

2. Selecting and awarding contracts through competition and reimbursing contractors on other than a cost basis.

3. Combining Medicare A and B administration in a single contractor.

4. Establishing the territories of these combined A and B contractors on the basis of geography, workload and potential for absorbing new health insurance programs.

We believe the achievement of these objectives will mean more timely service to providers and beneficiaries and more accurate program payments. At the same time, the cost to the government of Medicare administration should be reduced. There is much that we can do with our exisiting contracting authority to restructure our existing operational framework in accordance with these four objectives.

In PL 95-142 (the Medicare/Medicaid Fraud and Abuse Amendments), Congress gave us the authority to establish national or regional intermediaries by type of providers. This legislation was brought about by Congressional concerns over our administration of the home health agency benefit. Final regulations are about to be published which will permit us to implement this legislation.

This same legislation gave us authority to reassign providers from the nominated intermediary if that intermediary is doing a poor job. In line with this authority, performance standards for FY 1980 have been released to all Part A contractors. Standards for Part B contractors will be issued soon.

Contractors who fail to meet the standards will risk termination of their contract or modification in the scope of their service. Under our existing performance standards system, we have identified and put on notice several contractors whose performance is not satisfactory. Those contractors are now working to meet performance objectives established by HCFA regional offices and their performance will be reassessed before the next contract period.

There is a wide geographic dispersion of providers served by several of the large Part A commercial intermediaries. We plan to explore with these intermediaries how we might reduce this wide geographic dispersion into a more efficient arrangement. We will also be working with the Blue Cross Association to look at their subcontracts with local Blue Cross Plans.

As you know, we have used our experimental authority to introduce competitive procurement into the Medicare contracting process. Under the experimental authority contained in Section 222 of the 1972 amendments, we have implemented three competitively let fixed price contracts in Medicare Part B in Maine, Illinois, and upstate New York. In Illinois, our experiment has had numerous -- and serious -- problems. We are working closely with our contractor in Illinois to solve those problems.

We also initiated a Part A experiment in Missouri and a Part A and Part B experiment in the three State area of Colorado, Utah and Wyoming. In both these experiments, litigation is in process and future action is pending appellate court decisions.

While these experiments have not been without problems, we have gained valuable information and experience from them. As a result, we will strengthen implementation performance requirements, have closer monitoring of performance and better testing of operational capability. The latter is extremely important if we are to prevent serious disruptions of service. We will also guard against marketplace domination by individual contractors or groups of contractors.

Aside from our experimental authority, we want as a national policy to strengthen our entire audit and reimbursement activities, and if necessary, provide a higher level of funding for those activities than in the past. This, coupled with our emphasis on improved utilization controls resulting from increased PSRO activities and recent stepped up requirements for utilization screens, should provide better controls over program payments.

Currently, there are 119 Medicare contractors with 76 in Part A and 43 in Part B. Administrative costs are running about $687 million a year (Part A, $239 million and Part B, $448 million) and the total claims workload to be processed is at 208 million claims (Part A, 42 million and Part B, 166 million). If we modify our operating framework in accordance with the four basic objectives I just described, the existing contractor configuration would change significantly.

For discussion purposes we have defined a "model" configuration of 50 to 60 Medicare contractors with each contractor administering both Parts A and B in a defined territory. In determining the actual number of contractors in any new configuration, some other important factors to be considered are: (1) maintaining consistency with HEW regional boundaries; (2) using States as basic building blocks; (3) achieve, where possible, a workload for each contractor territory of four to ten million claims; (4) maintaining enough small contractors to assure entry level for new contractors; and (5) improve management of program payments and improve service to beneficiaries and providers.

We think that such a revised structure of Medicare contracting would bring about significant cost savings through economies of scale and reduced overhead costs. It could also result in improvement in the quality of services and in beneficiary and provider understanding. We estimate that such a configuration, if fully implemented, would result in administrative cost savings of over $120 million annually, measured against current costs.

I see an evolutionary process as the best method of changing our operating framework. We intend to consult with the industry, use our experimental authority to test our own ideas and those brought to us by the industry, and then make changes in a planned and prudent manner as contracts expire or poor performers are replaced.

Our authority to consolidate Medicare Part A and Part B, and to select contractors competitively and reimburse them on other than a cost basis, is limited now to the experimental authority contained in the law. Therefore, we will continue to seek the necessary legislative changes.

When legislative authority is obtained, we will develop implementation plans that are the least disruptive to beneficiaries and providers of services. Implementation will have to be phased in over a period of years and will be consistent with a national health plan. This will be a major procurement undertaking and it will be critical that we proceed consistent with our administrative capabilities to assure the least program disruption.

It is important to note here that we do not propose frequent turnover in contractors. Rather, with some possible exceptions in the smaller jurisdictions, we contemplate contract terms in the range of five years with built-in options for extension and renegotiation of price at the end of the first three years. The contracts also will include specific performance standards which address quality, accuracy and timeliness of payments. This will, as the President's Management Improvement Council indicated, stimulate competition in the marketplace.

We have developed a discussion paper on our contracting approach and we would like to have your comments and suggestions on the paper. Please remember that this document is a discussion paper and we are quite sincere in our desire to have your comments.

Process for Achieving Our Goals

I believe it is extremely important to articulate a long range strategy to developing health financing and information systems for the 1980's, and for refining our operating framework. We want to communicate our strategy to the public, our beneficiaries, the Congress, the existing contracting community, and those who may wish to enter the field in the future. Our views should be tempered by your advice. At the same time, we will pursue administrative actions and experimental initiatives consistent with our basic approach.

In all our efforts to improve the framework in which our health care financing system operates, we are committed to assuring that all affected parties are involved in the decisions made and the actions taken.

To that end, we initiated an annual regulations agenda setting process and published our regulations agenda. The agenda includes all the regulations we intend to consider over the next year. I believe that this is a good way to involve all interested parties in the development of our policies. However, it has not worked as well as I hoped it would. Regulations tend to deal with specific, narrow issues and not with the larger picture which is of concern to most of you here today.

We now will undertake an additional approach. We will attempt to identify clusters of issues that all of us will have to deal with now and in the future. We will describe these issues in the form of HCFA discussion papers. You have already received one such paper on CPT-IV and we are making two more available to you today. I invite and I urge your comments and suggestions on these papers.

We will consult with contractors, States, providers and beneficiaries on the discussion papers as they are developed. Meetings and public hearings on the various issues will be held to obtain the greatest possible input. From all the comments and discussions, we will decide on the direction we will take in the long term.

Final decisions on these issues will be described in policy statements which result from the circulation and comments on discussion papers. We are distributing one such policy paper today concerning the Annual Hospital Report. I hope that in all cases our actions will be consistent with the needs of other finance programs. I see our role as one of facilitating change. I hope that we will be following your lead as often as possible. Once we have charted our direction we will let it be known and will focus HCFA's efforts and financial resources accordingly. We will work through the issues slowly and thoroughly, but once we make decisions, all of our programs will fund only those operating systems that are compatible with our announced policies.

I am committed to the greatest possible involvement of the private sector in HCFA's decision making process. I am convinced that your active participation in this process is critical to the success of our efforts. It is also the only way that we can make sure that our actions contribute to improving the financing and delivery mechanisms of our nation's health care system.

HEALTH CARE IN THE 1980's

NATHAN J. STARK

UNDER SECRETARY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MR. STARK: In accepting your invitation to speak, I promised to focus my remarks on the future -- on trends I see developing and on planning now underway to prepare us for the coming years. I am certain you will understand if I approach those subjects with some hesitation. The pace of change -- in the area of health care and in every other aspect of modern life -- is intensifying so quickly that today's wisdom is often hopelessly out of date by the time tomorrow's newspaper hits the doorstep.

As risky as crystal ball gazing may be, however, no one seriously doubts the need for planning. Marshall McLuhan once said our generation has a habit of marching backwards into the future -- and none of us would argue that is the safest way to travel.

If the planning we do in the health area is to be effective, we must first take into consideration the broader perspective. We cannot consider the question of health care in isolation -- we must begin by asking ourselves about national trends, particularly trends in the nation's economy.

In that light, I was particularly interested in an essay which contrasted two outlooks -- appropriately named the "cowboy economy" and the "spaceship economy."

The first example -- the "cowboy economy" -- is based on a frontier mentality. It encourages rough and tumble, exploitive behavior. Consumption and production are to be encouraged at almost any cost -- bigger is always better -- and management and conservation of resources are given little attention.

The second example offered in the essay is based on the mentality which would prevail in a space capsule whose inhabitants must exercise great care merely to survive. Success depends on the expert management, conservation and even recycling of resources. Recognizing limits as well as opportunities, this model emphasizes both cooperation and planning.

There is little doubt that today's world is moving steadily toward the spaceship model. Our resources -- while still awesome -- are nevertheless finite, and the proper management of those resources is critical if society as a whole is to survive and prosper.

These larger economic trends clearly also apply in the health area, and they are particularly important when we consider the delivery of health services.

This is, in President Carter's words, "an era of hard choices and scarce resources," and it is not possible to talk about the role of the public and the private sectors in the health field without acknowledging that fact. Against that background, what can we envision in the coming years in health care delivery?

First of all, it is extremely unlikely that the role of the Federal government in health care will diminish. Now more than a decade old, Medicare and Medicaid have become widely accepted institutions which represent a national commitment to help the most vulnerable in our country -- the elderly and the poor. While both programs will certainly change over time, there is no real possibility that either will be reduced dramatically.

In fact, the Federal commitment in the area of health will almost certainly increase. The House has passed and the Senate is now considering the Child Health Assurance Program (CHAP) -- the Administration's proposal to extend health benefits to an additional two million poor children and 100,000 low income, pregnant women. The Administration's national health plan would make health insurance available to virtually all Americans -- including over 40 million who now have inadequate health insurance or none at all. Proposals such as these would substantially increase the Federal role by providing greater access to health care.

I believe that those particular measures are needed, but such an expansion of the Federal role in the health area carries with it an important responsibility. We must take these steps carefully -- setting standards and establishing policies which guarantee that programs provide quality care in the most cost effective way possible. I fully recognize that as the Federal expenditure for health increases, the challenge to manage programs efficiently increases as well.

That challenge of efficiency is by no means limited to those of us in the Federal government, however. The private sector -- doctors, hospitals, nursing homes, insurance companies and many others -- must also help control costs or we will find ourselves collectively priced out of the market.

I know that challenge can be met. An era of limited resources -- harkening back to the spaceship analogy -- need not be a period of hardship. It can provide us with important opportunities to experiment, to develop programs which will give us more service for the dollar.

For its part, HEW is moving in a number of ways to do just that.

Of direct concern to this group, I know, is our effort to reform a reimbursement system which provides few incentives to contain costs.

I know you are all too familiar with the shortcomings of the current customary, prevailing and reasonable reimbursement structure.

- It is confusing to beneficiaries and physicians because neither knows what Medicare will reimburse until carriers actually pay the claim.

- It encourages the use of high price, high technology, hospital based medicine over office based primary care.

- It produces unwarranted speciality differentials for physicians performing the same service. Further, its urban payments are 23% higher than rural ones. Both anomalies run counter to our efforts to redress geographic and specialty maldistribution.

- Finally, it offers inadequate financial protection to beneficiaries on the 50% of claims that are not assigned.

Those particulars do not describe the kind of system which provides quality care at a reasonable price. Clearly, we can and must do better.

A sound reimbursement system should be designed to meet three basic goals:

- o High quality care, efficiently delivered;

- o Broader physician participation resulting in wider access to care; and

- o Administrative simplicity for both physician and beneficiary.

These issues must be addressed fully in the current congressional debate on national health insurance. Of the various proposals now before Congress, I believe that President Carter's national health plan best addresses the goals of quality, efficiency and social equity.

It would provide all Americans with protection against catastrophic medical expenses and an additional 15 million Americans with fully subsidized, comprehensive health insurance. The national health plan also seeks to enhance competition among providers and fiscal intermediaries.

- o Employers would be required to offer their employees all Federally qualified HMOs. They would be required to contribute equally to alternative plans.

- o Individuals covered under health care, the public program for the poor and the elderly, would have greater access to HMOs as a result of the reimbursement reform I will describe later.

- o Claims processors would be selected on the basis of competitive bidding.

Health care would also establish important changes in the current inflationary reimbursement system.

- o Physicians, participating in health care, would be reimbursed on the basis of a negotiated fee schedule.

- o Hospital cost increases would be limited as prescribed in the Administration's hospital cost containment proposal.

In the next several minutes, let me highlight several other steps we should take short of the comprehensive reform envisioned in the national health plan.

A Carter Administration proposal which we are working to enact would permit Medicare payments to HMOs at a set rate based on Medicare's cost for equivalent services in the fee-for-service system. By simplifying the payment system, this would encourage HMOs to enroll Medicare beneficiaries. In addition, savings between the payment rate and the actual cost of services would be passed on to beneficiaries in the form of lower copayments. Beneficiaries would not be at risk for physician bills in excess of Medicare reimbursement rates.

Under the Administration proposal, for the first time, we would use the Medicare payment system to exert a constraining influence on health care costs. By promoting competition among delivery systems, we would encourage efficiency rather than continue to fuel inflation.

With the risk sharing approach, we also recognize the profoundly important role of physicians in determining utilization of health care resources. Experiments like Safeco's United Healthcare and Northwest Healthcare, for instance, make primary care physicians the focal point of health care services and give them responsibility for managing costs of all care -- hospitalization, referral-specialty care, ancillary services -- and these experiments deserve our full attention.

But physician reimbursement reform is only part of the solution. Nearly half of the health care expenditures are for hospital care, and we must concentrate here as well.

Hospital costs have been increasing at an average annual rate of nearly 15 percent for the past decade, significantly above the comparable figure in the consumer price index. This increase stems in large measure from general inflation, rapidly advancing medical technology, excess hospital beds, and ineffectual planning.

In addition, hospitals make more intensive use of personnel, tests, procedures and drugs than ever before. While it is easy to measure the costs of these changes, it is much harder to identify their impact on the quality of care.

What we do know from experience under Medicare, Medicaid and many Blue Cross plans is that retrospective, cost based reimbursement is expensive, inflationary and highly inefficient. Because hospitals can recover virtually all costs actually incurred in the provision of care to individuals by third party payors, they face few incentives to assure that services are provided efficiently and that goods are purchased at the lowest available price.

Moreover, generous treatment of costs associated with depreciation, interest, and equity capital have resulted in costly and often duplicative specialized services and highly sophisticated technologies. Often underutilized, such services and equipment cannot pay for themselves.

What can we do to alleviate these problems in the future?

The Department will continue to refine our measures of hospital case-mix and the effect of case-mix on costs. We can anticipate expanding the application of hospital cost limits to total inpatient operating costs.

In addition, the relationship between inpatient and outpatient costs must be explored further. Reforms which address only part of the hospital could result in unwarranted shifts of costs without reductions in total outlays for essentially the same services.

Cost containment legislation as proposed by this Administration is the best short term remedy for reducing the rate of increase in hospital expenditures. In the longer run, we can look forward to further efforts in at least two major directions.

The first of these is movement away from retrospective cost based reimbursement and toward prospective reimbursement.

Second, we anticipate continued development of the health planning process and a strengthening of the link between reimbursement and planning. This is particularly critical as we begin to examine the way in which capital expenditures drive up current and future operating costs. Continued research is needed, so we can develop policies that will reduce excess capacity where we find it and foster carefully planned expansion only when it is justified by population growth and changing needs.

Controlling costs is only one dimension of using our resources wisely. It is equally important to anticipate the special health needs of a changing population.

The growing proportion of those over 65 is a well recognized phenomenon in our culture. At the beginning of this century, the aged made up four percent of the total population. Today, they comprise 11 percent, and this proportion is expected to double in the next 50 years. In addition, among the aged, the number of people age 75 and older will increase from 38 percent to over 45 percent by the year 2000.

The health care needs of the aged differ in many respects from the general population and that is particularly true in the area of long term care. The elderly, for instance, make up approximately 86 percent of the nursing home population.

As I'm sure most of you know, there has been a historic bias in many of our coverage and reimbursement policies. The lack of sufficient reimbursement for community based care such as health, homemaker, nutrition and other services, may create an incentive to use nursing homes. Medicaid, the largest public payor of long term care, spends nearly 40 percent of its budget on nursing home care, yet only one percent on home health.

The President's 1981 budget contains several proposals to reduce such institutional biases and to promote equity among current program beneficiaries. While these proposals can be expected to produce some savings, the important feature is the greater freedom they give individuals to choose the care most appropriate for their circumstances. Elimination of the three day prior hospitalization requirement, for example, should discourage unnecessary hospital stays that might otherwise be used because they are an avenue to obtaining home health benefits.

In the course of my remarks today, I have touched on a number of important health issues and suggested several ways the Department is seeking to refine and improve programs already in existence. I know this group in particular shares our determination to operate these valuable health programs in the most efficient way possible, and I know we can continue to count on your support in the coming months.

As I look into the future, however, I cannot leave this podium without emphasizing the urgent need for greater access to health care in our country.

Although the health of most Americans has never been better, the health of far too many is still poor. Millions of our fellow citizens -- most of them poor -- are still denied quality health care because they live in rural areas or urban ghettos which are underserved by health professionals. Millions more -- again, most of them poor -- are denied care because they cannot afford its ever increasing cost. Too many of our fellow citizens fear medical bills almost as much as illness itself.

As long as those conditions prevail, we cannot say we have a health system worthy of this good country. We can do better, and in the coming months we must begin that task.

Earlier I mentioned the Child Health Assurance Program and the national health plan -- two Carter Administration proposals which represent a giant step in the direction of quality care for all Americans, regardless of income or place of residence. These bills can be enacted, and I strongly encourage you to help us win support for them in Congress.

Both bills are based on a fundamental partnership between the public and private sectors, a partnership this Administration is committed to see blossom in the years ahead. As one who has spent a career in the private sector, I believe such cooperation is vital if we are to tackle the problems before us, and I encourage you to join with us in such an effort.

Woodrow Wilson used to remind the nation that "Responsibility is proportionate to opportunity." The opportunities today cannot be denied, and I trust we will jointly accept the responsibility to work together to meet the challenges of the 1980's . . . to work together to better serve the American people.

Thank you.

HEALTH CARE IN THE 1980's

Moderator:
Peter Fox
Office of Policy Analysis, OLP, HCFA

Panel Participants
Earl M. Collier, Jr.
Deputy Administrator, HCFA

Louis Orsini
Health Insurance Association of America

Edwin R. Werner
Blue Cross/Blue Shield of Greater New York

MR. FOX: Welcome to the panel on Health Care in the 1980's.

Before I introduce the speakers, I'd like to read a story from this morning's Washington Post that goes at one of the fundamental economic and philosophical questions of our time, which is, what is a person worth?

The headline is, "Value of Body Rises by 643% to $7.98." The story goes on: "Double digit inflation has driven the value of the human body up by a whopping 643 percent in the last ten years, but it is still a bargain. The human body's minerals and trace elements, worth only 98 cents in 1970, are now worth $7.98." It's the closing paragraph I like: "The body is full of hot air. Oxygen accounts for 65 percent of the body's weight, carbon dioxide 18 percent, hydrogen 10 percent and nitrogen 3 percent."

If any of the other panelists or anybody in the audience would care to comment on this later on, they are more than welcome to.

I'm honored to chair a panel of distinguished speakers brought together by the Medicaid/Medicare Management Institute. The format will consist of each presenter having roughly 15 minutes, followed by a discussion among the panelists and from the floor. I would urge that everybody be free with their ideas. This is our opportunity to speculate about what the future might look like and how it will bear on all of us. At the end of the formal presentations, I may or may not throw in my own two cents worth.

The first speaker is Mr. Louis Orsini who is vice president and director of the Consumer and Professional Relations Division of the Health Insurance Association of America. Mr. Orsini joined HIAA in 1948, where he has served in a number of positions of increasing responsibility. From 1952 to 1963, he served as vice chairman of the Health Insurance Council, a federation of insurance associations, prior to becoming its first director. He is a guest lecturer on various aspects of private health insurance and the author of numerous articles on health insurance and health care cost containment, published in insurance and professional journals.

MR. ORSINI: In listening to the dialogue this morning and this afternoon, and respecting the moderator's suggestion that we talk for 15 minutes, I thought I would limit myself to noncontroversial subjects like the management of the health care system where we share a community interest with the Federal government, but really responding to the 95-5 percent equation. For those of you who want to talk about the contractor costs or the costs of administration, there are far more competent people than myself here from the insurance side and they can discuss the details in whatever depth you would like.

In listening to Secretary Stark's comments about the national health insurance issue, I'm going to resist the temptation to discuss that part of the question because we are on record, we have filed our testimony before the House Ways and Means Committee, and that, itself, could take all of the 15 minutes.

But we are interested in talking about the issue of how to manage the system. We are interested in talking about the planning strategy to be implemented by the planning law which is now in Phase 3. We are interested in

the objectives of the PSRO law, which was designed to develop the strategy through which we pay for necessary care, but encourage doctors to stop doing things that are wasteful. And we are interested in the longer range strategy of how do we establish pragmatic incentives to contain costs.

The dilemma that we have is because most of the approaches in this area have been fragmented in their impact on the system. For example, the Federal strategies in developing a planning approach have isolated planning from the reimbursement process, to a degree. They have isolated the PSRO process to the Medicare and Medicaid area and, to that degree, we find that much of what happens in the system simply takes the burden from one major payor and shifts it to another.

In the same way, as we look at the problem of cost containment, we find that, in looking at the longer range strategy of how you contain costs, there are a number of very, very popular options out there. First is the voluntary effort idea, which has a large constituency within business who are opposed to regulation, and they allege that they can do it better than anybody else. There are the marketplace options which are now being popularly held out to the consumer as, if you only knew enough about it, you could probably pick the least costly, most effective physician, and he'll take care of you on a cheaper basis, and that's all you need to do. And then, finally, there are those initiatives that are going on without new legislation, which tend to produce cost predictability for Medicare and Medicaid and which tend to swell the burden assumed by the private sector patient.

So, I think we are at the point now where we ought to be looking at and recognizing that what we need is no longer a confrontation between those who favor regulation and those who are for marketplace or for the voluntary initiatives. We need to recognize that government is here, the government has a role to play, and that we ought to begin to plan together as to how we confront the management initiatives.

When I use the term "government," I mean we've got to start talking with the Federal and State governments, and we need to bring into the dialogue those people from business and labor who are paying the bill.

Now, if we begin to do that, we've got to recognize that the planning law has developed some very serious shortcomings. As a cost containment strategy, it is going to be ineffective simply because it deals with too small a percentage of the total hospital budget. As a strategy for developing an informed consumer constituency to blunt the self-interest of the providers, it has developed some real problems.

We need planning. We need assurance that the system expands in a way which improves access to care. We need to provide incentives which respond to the problem that, within many communities, we have an oversupply of beds and it is merely the existence of those beds which is driving the inflation or the utilization of hospital care up by itself.

We have to recognize that the incentives to modify, to convert, or even to close -- not perhaps in that sequence -- have to be faced more effectively. We have not been able to close beds through the planning process. It's questionable whether we ever will be able to close beds through the planning process because of the high emotional content of the issue when it is debated within the community that is having beds closed.

So, we have to look at planning, assess where we are, what its accomplishments and problems have been to date, and then decide how we can test what needs to be done to strengthen the process. What seems to come through loud and clear is that planning, standing alone, will have limited impact and it has to be blended with some overall reimbursement strategy.

Now, let's look at the second piece of the pie, this whole question of how doctors use hospitals and whether the incentives that are out there currently will produce the re-examination of physician practices to deal with those situations where, over a period of time, the hospital use rate has been inflated because of the existence of differences of reimbursement, or because of the availability of beds, or simply because of physician convenience. How can we address those issues in a way that is going to make sense?

We've seen real progress being made by some of the HMOs and the IPAs as options. We've seen that the differences in hospital use rate, when you introduce an HMO and an IPA, in terms of what was going on in the community, can be somewhat dramatic.

What we have not really recognized, however, is that those same efforts have produced other problems. For example, we've seen that the IPA development in the Twin Cities, which has represented 75 percent of the physicians in their involvement, appear to be developing a dual pattern of hospital use: between 5 percent of the patients, who utilize hospitals under the IPA mode with the same doctors, and the other 95 percent of the patients being treated under the traditional fee-for-service mechanism, there's a 300 percent difference in utilization.

Now, some of that may be accommodated for by differences in age or population characteristics, but the facts are that we really ought to know why those changes occur and we ought to devise a system for addressing that kind of a variance in an intelligent way.

As we look at the larger question of how we contain costs, long range, everybody has their own ideas. We are not at any stage where we can say we've got a solid constituency with which we can march together toward one solution. We all have our own biases as to how to do it, and we respect the fact that some people think that the voluntary effort is really stimulating the private sector to do the things that need to be done to restrain cost increases. We have trouble with the voluntary effort accomplishments because of the softness of the information base. After all, the voluntary effort's measurements of progress are being based on increases in hospital expenses. That reflects what the hospitals spend, but we think the consumers are more interested in what they spend.

So, we think that when you measure the impact of the voluntary effort in terms of net patient revenue, you find some widespread variations in area by area, not the least of which is to track the impact of the rate of increase in net patient revenue in the seven States that had mandated programs for 1978 -- which was 9.7 -- with the other 43 States, which was 13.7.

Now, a four point variation in national expenditures for hospital care tends to exceed $3 billion a year. We can't ignore that.

When we look at the State mandated programs -- and there is no one option in that area that is doing the job effectively across the board, but they seem to show some more promise -- however, we find that they, too, have their problems. But what they have going for them, we think, is a better data base, a better information system, and we can recognize that what they are faced with is an across the board control, so the difference between the mandated programs and those that are not mandated is they either close out or minimize the option for cost shifting.

Now, where does this leave us? What I've tried to say is that planning at objectives we could all subscribe to -- they were public interest oriented -- we share what the government wanted to do through the planning process.

PSRO had objectives we could all subscribe to. We share what the Federal government wanted to do in the PSRO process. We share what the Federal government wants to do with cost containment.

What we differ is on how we get there. We think that at this stage of the game perhaps the most effective contribution that could be made is to back off and to stimulate a wide range of options for improving the effectiveness of all three of those programs, but to do it in a way where we have in place a management information system. This is where the Federal government has more leverage to stimulate the collection of that kind of information than any other single source.

We recognize the interest in integrated data demonstration projects and we are anxious to work with the Federal government in that area. We recognize the interest in standardizing the nomenclature and the coding, and we are anxious to cooperate in that direction.

But, does it go far enough? We think that there has to be a standardization of not only the elements of costs that are collected, so that as we compare competing options we are doing so on the basis of a comparable cost base, if it's hospital costs, but that we also have to be prepared to track variations in utilization by major sources of financing. By that I mean we should be able to break out baseline data so that we can follow, by hospital, by diagnosis, the experience of Medicare, Medicaid, insurance, Blue Cross, HMOs, IPAs, and all others. And, based upon that information, do our assessment of which of these initiatives work, which produce reciprocal problems within the system, which simply shift the burden to somebody else, and what's the direction we should all be moving in, together, to develop a uniform reimbursement concept which responds to public interest objectives, not to short range cost predictability strategies.

MR. FOX: The next speaker is Edwin R. Werner, who is president of Blue Cross and Blue Shield of Greater New York.

Mr. Werner has spent his entire career with Blue Cross and Blue Shield, starting in 1940 with the New York Plan. After three and one-half years in the Army, he joined the Chicago Blue Cross/Blue Shield Plan. In 1957, he joined the Blue Shield Association as assistant to the president.

In 1961, he returned to Blue Cross in New York City as vice president for marketing, and then held various senior level positions until he bacame president in 1972.

Mr. Werner was instrumental in effecting the Blue Shield-Blue Cross merger in New York City, the largest merger in the history of the Blue Cross/ Blue Shield system. He has been active in the New York State Hospital Review and Planning Council, the New York State Senate Health Advisory Committee, and the New York State Health Care Financing Council.

MR. WERNER: Somebody once said that an expert was somebody more than a hundred miles from home, and I guess that suggests that when he or she is a hundred miles from home, there is nobody around who knows whether his or her field of expertise is really legitimate or not.

Well, I'm almost 2,000 miles from home, but I'm in a peculiar position. You heard from Leonard Schaeffer this morning. He spent some time with CitiBank, which is in New York; Duke Collier, whom you'll hear from in a few minutes, clearly got more than a mild exposure to New York when he passed through there as Deputy Director of the Office of Health Systems Management; and Lou Orsini's office is just a little bit up the street from me, in the high rent district; so I disqualify myself as an expert.

The Under Secretary was very generous in his opening comments. He said he was glad to be in Dallas away from Washington where all he heard about were the unique and serious problems in New York. Well, here I am, unique and serious.

Unlike Lou, I will tend to be a little more provincial in my comments, although I hope some of them have some bearing on more than the New York scene. My reason for being provincial and my justification for it probably comes from a rephrasing of a line in a very popular song from a very popular New York show in which the star said, "If you can make it there, you can make it anywhere." She was talking about the Big Apple. My paraphrase is: if it can happen there, it can happen anywhere.

We have some unique situations in the New York area, which I don't wish on any of you, but I suggest that they are worthy of some recognition, both by you and by the Administration and by HCFA.

I was particularly impressed with the Under Secretary's comments about the desire to move from retrospective reimbursement of institutions to prospective reimbursement of institutions. We think -- although there may be one or two in the audience who would quarrel with me -- that we were first in New York. The Blue Cross Plan moved to prospective reimbursement immediately after a change in the law in 1969, and we think it has made a noticeable contribution, and it is also the reimbursement for Medicaid in New York. We think it has made a noticeable contribution to single digit increases in reimbursement levels to New York hospitals, not just in 1979, but for five prior consecutive years, while the nation was seeing double digit with great regularity.

I was equally impressed with his concerns about home health services as an alternative to expensive, acute general hospital care. We take some pride in that, too. We moved into the home health care concept, and to a benefit

structure that incorporated it in 1957. We are completely convinced that it is, in many instances, a viable alternative to horizontal care in hospitals and, clearly, a cost effective movement.

I share with him and with you a concern for the planning process. Although I think planning has done well in some locations, -- it has certainly made an impact on the New York environment -- I have been troubled during my term on the Planning Council in New York by what I believe is a lack of a major game plan.

There is evolving in the New York environment, and in other places, a view toward doing two things: one, most importantly, is to have a broad-based community plan for where health services need to be in the days, months and years ahead. Secondly, an active participatory in testing the experiment in the "batching process" for projects, so that a planning council is not looking at projects out of context without a full relationship to how the projects bear on a game plan which makes some sense.

I sit here and say to you this afternoon that, clearly, in my mind, the cost of health care is going to continue to rise. The commitment that has been made by Medicare to the aged, by Medicaid to the poor, and by Blue Cross Blue Shield and the insurance industry to its insured, is not going to be fulfilled without more money. On the other hand, that is not to say that I condone or believe that all of the "more money" that providers may ask for is appropriate. Conversely, I do believe -- and I think this is where the thrust of this group and all that we represent, collectively, has to be brought to bear -- that we need to be as concerned about how many units of care are used, as to how much the unit costs, and what kinds of units are being used.

I grieve that I sit here this afternoon and say to you that there are many people in hospitals in New York for only one reason: they are in acute general care facilities because there are not enough long term facilities to accommodate them. I suggest additionally to you that there are needed incentives and assurances, either to create those facilities, or to the extent that we are overbedded, to reduce beds. The Federal government and Medicare, the State and Medicaid, Blue Cross Blue Shield and others need to assure those providers, whether voluntary or proprietary or governmental, that during the transition period, as we move those beds from unneeded acute to needed long term, they can do so with some protection against the risk of loss.

Without that, we get what all of you have read about and some of you have felt -- community pressure, political pressure for hospitals that are about to close, to do nothing but stay open, to demand all kinds of infusions of funds, both public and private, to maintain them in the status to which they have been accustomed. That is not in the public interest. It is not in the interest of Title XVIII or Title XIX, nor in the interest of the self-sustaining portion of the population.

We certainly have compressed the revenues of institutions in New York, as they have been also in some other parts of the country, and a few hospitals have gone under; they've closed, become parking lots, apartment hotels. Yet, I'm not sure, sitting here, that the right hospitals have closed in the right areas. It tends to be the weak ones. It tends to be those whose costs are low. I ask you to figure for yourself what happens to the patients that would

have been there. They leave a $150 per day facility, and more than half of them find their way into a $300 per day facility; we haven't gained anything, from an economic point of view. I recognize, however, that we made some sound qualitative, geographic, and depth of service decisions; the problem is "may" -- the degree of certainty is unsatisfactory.

We need mergers of hospitals and, again, we need some assurances. Let me give you an example.

Two of the more prestigious hospitals in New York, St. Luke's and Roosevelt, both on the west side of Manhattan, both affiliated with the same medical school, saw a desire, a need, an opportunity to merge. One is roughly a 600 bed hospital and the other an 800 bed hospital. Clearly, in the long pull, in my judgment, that was a wise thing for those two hospitals to do. And yet I tell you that without the assurances from those who control the purse strings that the short term immediate increase in cost, which is inherent in such mergers, would be financed while programs are compressed and physical plants are adjusted, this very worthwhile merger would never have occurred.

We have to find the incentives to encourage change and, if that means some short term money for long term gain, I submit it is important to all of us.

Today the fight is escalating to pay more physicians by fee schedule in lieu of the way in which physicians are now compensated. I have no quarrel with fee schedules. My record on that is abundantly clear. It seems to me, however, that if we are going to have fee schedules, we must decide in what areas they will apply, at what level they will be cut, and how do you make appropriate reductions for the present form of reimbursement. Clearly, if the commitment of Congress intended by Part B is to be met, then fee schedules have to attract at least as much attention and support from the profession as the "assignment" process does now.

I would say to you that the governmental forces in 1966 did not believe that assignments would fall to the 50 percent level. Certainly a lower level than the commitment that Congress intended to make to aged people and, yet, to do anything with that, clearly is going to cost more; but the answer is not necessarily to do so through fee schedules.

I would like to encourage some dialogue this afternoon on the question of how do we move people to use the multiplicity of provider resources available to them more effectively. There needs to be some incentive for the institutions and individual and group providers willing to cooperate with efforts towards increased use of ambulatory and home care experiments. Only then will more facilities be closed, so that new patients don't find their way in, occupancy levels don't stay high despite what you do about alternate delivery systems. There must be some incentives for them to do so, some assurances that they will have adequate revenue during the period of time when transition is occurring.

I now change gears only to make what I suppose is a controversial point to some, but I think important. It seems to me that when Congress enacted Title XVIII, it intended copayments and deductibles, but I'm not sure that it

could see 15 years ahead and realize what would happen to the burden that falls upon aged people to pay those deductibles and copayments. If they could have seen $40 become $180, if they could have seen the copay of 20 percent in its relationship to today's physicians' fees, they would have seen what I think all of us see, a pretty heavy burden on the aged to pay for that portion of their health care not compensated for under Medicare. Truly, if we are going to control the aged portion of payments in relation to the economic index, then, I submit to you, it bears very little relationship to their income, whether it be Social Security income or fixed income from an annuity, etc. Thus, the commitment of Congress isn't being kept quite as aggressively as it should be. We need some type of a cap on that portion of the burden falling on the aged people. Using copayments as a utilization control has yet to be proved, and using them to lower the cost to the government is not totally fair to the aged. If we are going to continue in a double digit inflation economy, we're going to skyrocket deductibles and copays as they are presently legislated, and we are passing the burden on to those who can ill afford to pay for it.

Now, all of the subjects that I've mentioned are intended to stimulate some dialogue and really have a theme. If it hasn't come clear, let me make it so to you. There are a series of forces at play in health care financing and impacting on the health care system -- Medicaid, at the local-State-Federal level; Medicare, at the Federal level; and very clearly, the large private sector third party payors. If we want to impact on the system, if we want to make providers change their ways, if we want to make patients change their habits, then a closer partnership between these three groupings is essential.

I would suggest also, with all due respect to the Federal establishment, that some of the solutions to some of the problems are necessarily parochial, they are provincial; they must be tailored to local circumstances and are not conducive to a single national utterance that says, "This is the way it is going to be."

So, in summary, I am suggesting that we discuss this afternoon, in part, how that partnership can work better.

I understand there was some discussion this morning about fixed price and administrative cost. I admit to being aggrieved at what I have perceived to be more attention to the three percent program cost which goes to administration, and less concern for the 97 percent that goes for benefits. Truly, I accept the fact that administrative costs should be as low as possible, but they should not intrude on our ability to impact the health care system because that's where the big money is for now and the future.

MR. FOX: The next speaker is one of the many people in Washington I get to take orders from, Duke Collier, who is a lawyer trained at the University of Viginia, with his undergraduate degree from Yale.

Duke spent several years with the law firm of Covington & Burling. In 1977, he became executive deputy director of the New York State Office of Health Systems Management. In July 1979, he assumed his current position as the deputy administrator of HCFA.

MR. COLLIER: It is fascinating, at least to me, that the podium has Orsini and Werner and all of us fresh from New York, and Ed made a point of that and it was not to be taken lightly.

If we are at a time of constricted resources, as I believe we are, then I think the best laboratory for study is New York State, which ran out of money sooner and more dramatically than anyone else, and the responses to which I think should tutor us more than any other.

This session is the most problematic of the sessions. This morning was what everyone came to hear about: what are you going to do to us, et cetera. This one is a little more problematic, but I think it is the most interesting session, potentially.

First, I'd like to give you some of my perspectives. Gas prices provide a lesson for our times in some ways. It is the most fruitful analogue to me. In the late 1960's, early 1970's, even before the boycott, GM had thought to redesign its fleet and retool its factories in order to produce smaller, lighter and more fuel efficient automobiles, and at a cost of many billions of dollars, and in retrospect, if you're fair to them, at some corporate risk, they did that, but Chrysler did not. I think the comparisions today are fairly striking in terms of the success of the one corporation as opposed to the other.

In Europe, where gasoline has cost a good bit more for some time, the fleet economy, miles per gallon, is close to 30 miles a gallon, and I think I say that simply because the Europeans still drive around, although in somewhat smaller cars, and they even tend to drive around a little slowly. We'll always drive around here, too, I think, although more and more in Citations and less and less in Cadillacs.

I think that is true with respect to health care. We are going to continue to drive around, but my guess is that the boom days of big time tertiary medical centers are somewhat behind them in some respects, not all, but it will not be possible for everyone to have a Cadillac in the neighborhood. Indeed, I think it is increasingly the case that acute institutional care is going to be evolving substantially and become less of a factor for all of us.

I want to come back to that theme because I think that has major implications to you all and I want to talk about it specifically in terms of primary care and long term care.

If the New York situation is of any use, it seems to me that what has happened up there is that under pressure from the limited budget that the State and city have, if Medicaid has begun to pay less, in all likelihood it has not been so much at the cost of Medicaid patients -- in the sense that it appears that Medicaid is still carrying its own load. There is some controversy about that, but what's happened is that in the Health and Hospitals Corporation, in Brooklyn Jewish, and in a number of other situations that have come to the brink of bankruptcy, it has isolated problems in those institutions which were always able to be sloughed over before, problems attributable to poor management in some parts, problems attributable to patients who have no coverage but whose coverage could always be subsidized out of excess revenues from the people who were covered in the past, but that can no longer be cross-subsidized.

It seems to me that the lesson there is readily available -- that is going to happen more and more as Federal government expenditures, on a per beneficiary basis, decline as they inevitably have to, at least as against inflation and the rest of the economy. They have to decline in some respects because we are under such pressure to spend more money for more people. CHAP would add, I think, two million people to the rolls. The National Health Plan, it's not clear -- 15 million I think the Under Secretary said, although the estimates vary. Just in terms of coverage, estimates would vary, but a National Health Plan would take our expenditures in today's dollars from somewhere in the $50 billion range perhaps to 70-75, perhaps even more, depending upon exactly what components were introduced. Most of that money would not be for enriched benefits for any present beneficiaries; it would be for additional beneficiaries, and so forth.

So, I think we really need to look at retooling; we need to make our cars a little smaller and get a little more mileage out of them in order to make these programs go along better.

How are we going to do this? It seems to me that is obviously the one essential issue. A number of techniques seem available at the moment, and I'll just touch on them for what they are worth and, hopefully, we can discuss them some more.

Prospective reimbursement, as a device for controlling with a greater degree of certainty, expenditure levels, certainly is on the horizon, and many of you may operate in States where it is already available as a technique for at least Medicaid.

We have experiments now -- some of them well beyond the experiment stage -- in New York, New Jersey, Maryland, Massachusetts, Washington State, and western Pennsylvania. We anticipate applications in short order. I think they've already arrived from California, possibly from Illinois. I think we have recently approved Idaho.

If you think of it in terms of the Medicaid expenditures that are covered by those States, you don't have to add Michigan, Ohio and Pennsylvania before you've really got the bulk of the Medicaid expenditures.

And Medicare, which is already participating in New Jersey and Maryland, will follow soon behind.

The next thing that will come, I think, as we gain facility and control of expenditures, as pressures are put upon us on the budget front, will be less willingness to continue cross subsidies, particularly with medical education and research and secondarily, I suppose, of other patients. Also, in New Jersey and in Maryland to some extent, we have explicitly contemplated the possiblity that funds saved by the prospective reimbursement technique could be reprogrammed for purposes of taking care of indigent patients.

Certainly the cross subsidy issue will become much more explicit, much more on our minds, as we move into prospective reimbursement systems that rest upon uniformly gathered and uniformly massaged information.

With regard to other techniques, Lou Orsini certainly highlighted one which would be that of more controllable reimbursement techniques with planning goals and planning processes. Again, New York is instructive in this respect. I had the pleasure of signing the letter, in my old job, to St. Luke's and Roosevelt, in which the New York State Health Department agreed to abnormally high or higher than what would otherwise have been available reimbursement rates for the merged institution, based upon their assurances with respect to the combined budgets, pro forma budgets, of the merging institutions. The same was true with Buffalo General Hospital and Deaconess in Erie County. In the case of Buffalo General, they offered us pro forma budgets for the two institutions that were three percent in excess of the budgets for the previous year, and the promise that the budget for the following year, 1980, would be at about the same level of increase, perhaps five or six percent.

My understanding from Buffalo General -- just recently, not yet audited -- is that in addition to that -- over the top of that rather modest cost increase of three percent, the combined institutions -- without significant program changes, I might add -- were able to save an additional $700,000 or so in the first year of the merged operation.

We have regulations in circulation within the Department at the moment which would allow Medicare to become party to similar kinds of arrangements; that is, party to closure and coversion of merger type situations, which we would be willing to pay somewhat enriched rates in order to eliminate obstacles that might otherwise exist to desirable planning goals.

One of the other things you might want to keep your eyes on is of extreme interest to the Department, and that is the Bedford-Stuyvesant demonstration proposal in New York City. It arrived on our doorstep in the fall, and there has been a tremendous amount of controversy that surrounded the Brooklyn Jewish Hospital, which had been in Chapter XI for some time and which was faced with closure, the State having propped it up to some extent, over time, with direct subsidy and somewhat of an enriched Medicaid payment. The Department was sought out as a saviour of that hospital and a great deal of pressure was put on us.

We felt, looking at the service area which encompasses the Crown Heights-Bedford-Stuyvesant area, that there were many desirable aspects to the continuation of the Brooklyn Jewish, St. Mary's Hospital, St. John's Episcopal, and a number of clinics in that area, and some desirability in trying to get them together so that some of the problems they were facing could perhaps be resolved better through planning. That would perhaps wind down the same degree of inpatient care as has been available in that community in the past, increase the number of clinics, increase the number of doctors; in short, do all those sorts of planning things that people talk about rather faciley at these kinds of meetings.

Recognizing that you can talk a long time about health planning, much as the weather, but very seldom do much about it, we decided to hook our reimbursement programs up to it and make some money available to them if they would do the things we wanted, and take that money away if they wouldn't. Recognizing further certain limitations in our vision of the future in the sense that the configuration of health delivery in any given community has to

be very much a matter of local demography, practice patterns, what have you, recognizing that it is a highly political process, recognizing that it is impossible to impose solutions from top down even if we had them, we contented ourselves with putting in place a rather rigorous negotiation structure, a framework, in which we and the other payors would be negotiating over the period of the demonstration with the hospitals brought to the table as an incorporated group, again with the carrot and stick of our reimbursement available or not available.

I think it is a very interesting program. I hope that you will pay attention to it as it goes along. But, again, it is simply another example of our increased involvement, the reimbursement program's increased involvement with matters of health planning, matters of shaping the array of the delivery system. It has the possibility of offering us some techniques for achieving some of the goals that I think are going to be upon us.

I'll just touch on a couple of other things. It is quite clear that staffing policies, Federal staffing policies, have made a tremendous difference in the way in which services are delivered, and it is equally clear that those policies are in a state of flux and will be undergoing change; whether the issue is money for the training of doctors, the introduction, through our reimbursement programs as in the rural health program, of recognition for the paraprofessional, paramedical extender types of personnel, whatever, there is going to be substantial evolution in staffing policy over the next decade and it will have significant implications for our programs.

Two more points: If we have a sense of direction, or at least of the pressures that will be on us, and of some of the things that need to happen; if we have a sense of some of the techniques that are at hand, what about the style in which we'll be proceeding? I think no particular promises are available, but, on the other hand, certain things are inevitable and one is that we move slowly, we move incrementally. Global plans are hard to conceptualize and impossible to implement. It's not part of the deal in the constitutional scheme of things and never will be.

So, I don't think we'll see too much happening very quickly. On the other hand, I think it's imperative that where leadership can be provided in the structuring of the dialogue, that it be provided. I think you all are at a point at which leadership can and must be provided. I think many of the trade associations have not done the job that they could do in providing leadership, and they're going to have to do it more.

I think we have not done the job that we might do in providing leadership, but we are tyring to do it more. And if there is a promise of HCFA, as opposed to SRS and BHI, and so forth, I think it is that at least we have enough of an overview of the Federal programs to provide some sense of leadership from where we sit, and that will be something we'll try to do. But it will be a muddling through process, very incremental, a lot of demonstrations and experiments, and a lot of tries that fail and tries that succeed only partially. That's life. I don't think that is something to be pessimistic about; I think it is something to be optimistic about. At least there is ferment, at least there is movement.

What are some of the implications of all the preceding for you all as contractors? The closure and conversion regulations in circulation in

the Department may well have some hints there. You are us, and if these are goals, things that we're trying to produce, if you sign on with us and take our money to run our programs, then you are going to have to do what we intend and, with you, want done.

The closure and conversion regulations call for the contractor, the intermediary in the community, to be our negotiators in these closure and conversion situations. Who should know better than you what are the sensitivities of a given setting?

It is the same thing with a State. When I was in the State, acting on behalf of not only the State but the Federal government, I actively participated in negotiations between St. Luke's and Roosevelt, Buffalo General and Deaconess, New York Infirmary and Beekman Downtown, Brooklyn Jewish, Bronx-Lebanon. I think that is a role the States will have to play, and many are playing, and is a role that contractors are going to have to play. It will not be enough simply to pay the claims and operate at arm's length. I don't suggest that you've done that, but I think your role will be greater in this respect.

Ed Werner pointed out that situations around the country vary substantially and solutions in the problems that arise, in many cases, have to be tailored locally. I agree with that and I think that, in our program, we have a peculiarly appropriate set up for doing that in the sense that we have so many contractors who are tied in and knowledgeable about the situations in their local communities. That is not to say that we don't want a certain uniformity with respect to many of the things that we do.

A second implication clearly is that management is of far greater importance to us now than it used to be in the health care sector. The management of hospitals, the management of insurance programs, the management of the public agencies is the GM thing again: we simply have to be able to get the most out of what we have, the most out of our resources.

I talked, both formally in deposition when I was working for the State as a lawyer, and informally over the months and years I was in New York, and sensed there are a lot of hospital administrators up there who are some of the most embattled individuals around. I don't think I ran up on very many who really felt that they were doing a good job of managing their hospitals, and I ran up on an awful lot of hospital administrators who pointed out to me that they could do a much better job. And indeed, in the New York situation, for the first time had been given that opportunity because now their boards were, all of a sudden, worried, were backing them up.

I have talked to a number of people who have observed the health insurance industry for a while, and many of their comments about the management of health insurance programs have been quite critical. I am not an expert and I can't evaluate those comments, but it seems clear to me that the opportunities for better management are there.

I think HCFA bespeaks the opportunity for better management of public agencies, and I think we are doing a lot to manage our programs better. The contracting initiative is an aspect of that, but there are many aspects that run far deeper in terms of the 4500 immediate employees of HCFA that we could spend some time on.

In any event, that is an implication for the future for you, and I think issues of uniform reporting and uniform data and so forth are simply just aspects of that.

I've really gone on a bit longer than I had planned. I hope the comments I've made will get some juices flowing and people will start talking. It seems to me that we have one of the great luxuries of people who have to work for a living, which is that we have work to do which is fairly interesting, which matters, in some sense of the word, and that could not be more glamorous, at least in the sense of the interest that people take in it.

I've been struck, since the early days of my Medicaid litigation experience, that I couldn't fly on a plane, look at a television set, ride on a railroad train, whatever, without someone reading something about one of our things, without turning open a magazine and seeing something, without hearing people in the seat behind me talking about it, employed in it; it's an absolutely pervasive and interesting complex social issue, so I think that at least we can take some comfort in that.

MR. FOX: Before opening up to comments and questions, I'd just like to discuss three pressures that I think are critical to understanding the likely events of the next decade.

The first one, as Duke alluded, relates to staffing resources planning. We've talked a lot about the need to essentially bring together, at least at the local level and also at the Federal level, reimbursement with facility planning, but we haven't talked much about bringing reimbursement together with staff resources planning. I would submit that the great inflationary pressure of the next decade will come less from the third party payment structure than it will from the expanding supply of staffing, particularly physicians, generated in large measure by Federal policies.

To give you some idea of the magnitude, in 1965 less than 9,000 students entered medical school. This year more than 18,000 are entering medical school. If you project that out over a 30-year period, you indeed get a doubling in the supply of physicians.

If, in fact, doctors can, in large measure, generate demand for their services, then the inflationary impact, the impact on aggregate expenditures, is going to be enormous, and we are likely to see an increase in the share of GNP going to the health sector from roughly nine percent today to something in the 12 to 15 percent range within a few years.

The impact of the process, on the system, of political response, will likely be profound.

The second issue I'd like to raise is -- and it is going to drive some people up to the ceiling, I can guarantee it -- how much money can we afford to take from the pockets of working people and put into the pockets of the aged?

Let me give you some numbers. Everybody has been concerned with Medicare going up at roughly 15 percent a year. In June, Social Security cash benefits will go up by 13 percent a year, and there will be a further increase in the Social Security cash program similar to that in Medicare, as a consequence of adding 600,000 people to the rolls. As a result, roughly 15 percent increase in cash programs, along with the 15 percent increase in Medicare, is being financed through an eight percent increase, give or take, in wages. At some time, this is likely to cause enormous social tensions.

Again, where those tensions will lead us, I'm not going to say.

The last comment which, again, comes back to some of the other remarks, relates to data. I think everybody agrees that we will have a more planned and managed system. That isn't to say that the Federal government is going to do the planning or managing, although, hopefully, we'll do a better job at it, but it will be more planning and managing at the level of State and local government planning agencies and at the level of the individual institution.

The role of the administrator of hospitals is changing. There are more health maintenance organizations coming along, all of which are managed systems.

The greatest source of data rests with the payment process. That data was set up to pay the bills with very little more in mind, and there is going to be increasing pressure -- we see it now -- to change the data collection mechanism to do more than simply shovel out the money. Again, how that will play out, I don't really know. I also do not know what the data will look like, whether we have sophisticated planners around to use the data, or whether we can make the transition from a claims payment process to a management process.

At this point, having heard three very excellent presentations, I'd like to open up the discussion to the floor.

MR. MARKSON: I'm David Markson from Blue Cross of Greater Philadelphia.

I was wondering about what appeared to be possibly a conflict of objectives and goals. We listened today as Mr. Schaeffer described a program, a model, which I guess, if fully implemented, would produce, through the combination of A and B and the use of the larger geographic areas, by and large much more complex, larger and more geographically dispersed contractors.

This afternoon, I heard this panel -- Mr. Collier, Mr. Werner, and others -- describe the important role of the local contractor in relationships with providers of all types, institutional and otherwise, and relationships with the individual communities, to produce local goals. It occurs to me that unless this process is carefully and cautiously managed, these goals could be moving in different directions, and I was wondering if you, Mr. Collier, or any member of the panel may have some light to shed on that issue.

MR. COLLIER: I don't have any light to shed on the final conclusions. I think that, philosophically, it's an interesting issue, the competition -- the notion of Federalism in our society, competition betweeen local concerns and centralized concerns. In terms of our programs, I think that we don't now

know; we have some ideas but we don't have a final conclusion, and I think we've tried to stress that all day, as to what would be the optimal workload for a contractor, what would be the optimal geographic arrangement for a contractor.

I think we feel that program administration would be improved by adjustment in the number of contractors, downward, the readjustment of the workload, but I don't think we have a final conclusion as to numbers of claims, numbers of provider service, numbers of square miles covered, if you will, at this point. It seems to me that's probably not an analysis that is able to be done in the abstract, in any event. Situations vary tremendously. It is sort of like trying to figure out what is the right sized unit of government for maximum economies of scale and all these discussions of the Toronto system and sewer districts versus educational districts, decentralization of this and centralization of that, really probably haven't led us anywhere, although I did have a friend, who is a social scientist, tell me once that the optimal size of a city was 250,000, so at least I've been able to cling to that over the years. Of course, his insight doesn't seem to have helped any in setting up cities, but it is nice to have the comfort of certainty about something.

So, I don't have a lot of conclusions. In a fairly large State, with a lot of people and a lot of miles to cover and some rather disparate terrain, demographically and socially and what have you, I felt that if the State government was able to be reasonably sensitive to the disparate needs of the people served, that at least there was some homogeneity with respect to the traditions of the State, we didn't have too much discomfort dealing on any given day with Buffalo, Rochester, Glens Falls and Manhattan. I don't know how to respond other than to say that I think that the issue is an important one. I don't think that Federalization of these programs, a centralization in Washington, makes much sense, but other than that, I haven't reached any conclusions.

COMMENT: It seems to me the points you made draw out very starkly the difference between the role of the insurer, as simply a claims processor or as part of the health care system. There's an opportunity out there to demonstrate that the difference between policy at the Federal level and the way in which it is handled at the local level is going to be directly influenced by the degree to which we can maximize our consumer advocacy role in the process.

By that I mean that there is need for informed judgment when you discuss how the planning process changes. There is need for informed judgment if you are sitting in a State where there is a rate review commission that is drifting in the direction of being dominated by the provider or drifting in the direction of being too arbitrary.

There is need for informed judgment in developing the kind of incentives in the reimbursement system so that the hospital that has been generating or maximizing revenue by playing the utilization game faces a pragmatic incentive to live with a revenue cap, and living with a revenue cap independently arrived at has a pragmatic incentive to let utilization drop to its normal level and thereby maximizing profit and reducing expenses.

So, I think that the opportunity is there and I think if we limit our sights too narrowly, that clearly the role of the claims processor has limited potential.

MR. WERNER: I don't know what the optimum size of a city ought to be, Duke, and I won't sit here and say that precisely the number of intermediaries and carriers you have at the moment is the right number. I'm sure it isn't. I'm not sure whether I think it ought to be more or it ought to be less, but I'm sure of one thing, that the answer to Mr. Markson's question has its roots in what you expect the contractor to do.

To the extent that you want the contractor to play a role in the interface with individual situations, with reimbursement implications, with impacting on the delivery system, with mergers of institutions, with the movement of patients from one setting to another, with the way physicians practice, then there's a great deal to be said for the local familiarity, the relationships that have existed over many years. If you are really talking about the broad role of what I believe the contractor ought to do -- and one can fault some of us who may not have done as much about this as we were expected to do -- some will say that much of that initiative has been taken away from us.

With all due respect, I think there are significant differences between New York City and upstate, and not everybody is a Duke Collier who can move from one of those environments to the other and deal with them effectively.

But, if all we are talking about is pushing paper, if all we are talking about is pushing something into a machine and taking what comes out of it and putting it in the mailbox, then you've got one kind of an issue. On the other hand, if you're talking about impacting on the system and using the resources those contractors have available to them that can be of sevice to the Medicare program, then it seems to me that one has to pay some attention to those local relationships and protect them as best you can; in concert with good, efficient administration and reasonably balanced across the board dollar value for the investment.

MR. COLLIER: Let me pick up on those things, in the interest of some dialogue, because I think it touches on a point which, if we are playing our cards right as a conference, will suitably link this afternoon's session back to this morning's, to serve various pedantic purposes there, Bob.

It seems to me that one of the insights that we have had simply by the dint of our efforts once we got going on this is to recognize much more clearly, from a program management point of view, the disparity or the differences in the functions of the contractor. Clearly, claims processing is much different from A&R, much different from provider and beneficiary relations and much different from medical review. It seems to me that we haven't fully explored for ourselves -- though we now want to, and that was a point we tried to make this morning -- what are the implications of that difference for the way in which we do business.

It is not inconceivable that we may want to enter into different kinds of contracting modes. Certainly we want to approach the contracts differently for claims processing than for, for instance, A&R.

One of the interesting things to me in one of the PMIC discussions was Joe Connor from Price-Waterhouse, who wasn't here today, represented by Jack Buelt, talking about the freight forwarding business, which had for years had a fairly substantial auditing problem and which has generated a whole industry of people who have a specialization in the auditing of freight forwarding

activity. It seems to me that, implicit in some of the work that we have been doing -- and I hope now, from this day forward, explicit -- is that we are open to a lot of conversation and a lot of thought about that kind of approach.

It does not seem to me inherent in the scheme of things in the world that A&R has to be done by the same contractor who does claims processing, nor does it seem to me inherent that we need to have a single contract, once for all time, with everybody for everything.

Those are issues, those are open issues. That's the kind of issues that simply has to be debated, issues as to which principled people can disagree and have something to contribute.

So, I think that if there is a lesson out of this afternoon's or this morning's discussion, it is that the evolving role of the contractors will substantially influence the way in which we approach our relationships to the contractors. Competition is one catch-all for that, but it is simply one. I think there is a sort of whole functional set of relationships which go beyond the selection of a contractor and go really to the issue of defining the work the contractor is going to do and figuring out how to select and how to pay that needs to be very much on our minds as we move along.

MR. ALLEN: I'm Paul Allen, the director of the Medicaid program from the State of Michigan, and one of my official ad hoc duties is a member of the State Health Coordinating Council, which is part of the grand health planning system of this nation.

In the past two years, we've turned out a health plan for the State of Michigan that weighs about six pounds. This document, to me, is the idealistic translation of the national health goals into Michigan health goals. It tries, in each area, to speak to the things that you gentlemen talked about this afternoon, and some of the goals. Of course, a planning process says you have to come up with a blueprint to do something, if it is going to be worth anything, and this blueprint does things that are most frightening, and once you've got a plan, as we have, and then try to implement it, that's when the trauma starts.

Now, let me give you a specific. Health manpower: We have three schools of medicine and one school of osteopathy in our State. We have decided that we're putting too many physicians through these four schools, so now we have a quota system established, Statewide, on the number of physician candidates we will allow into these schools.

Now, that has just hit the fan in the past six months as we've exposed the plan to the legislature and the public. But it is a perceptible movement in the right direction, and I'm just illustrating it because that's the only way it is going to happen nationally. You made the point about demographics and local needs, and this really hits home with that point.

Related to it, we've also come up with an excess of 3,800 hospital beds in the State of Michigan that have to be reduced, without replacement, in the next five years, and we specify that 2,600 of them have to come out of Detroit, which is our New York City and Illinois' Cook County. Now the

question is whose 2,600 beds and, in Detroit, which brings out spiritual aspects of health care because we have the Catholic hospitals, the Methodist hospitals, the Jewish hospitals, the Lutheran hospitals; it brings out the racial aspects of health care: the black hospitals, the white hospitals; it brings out the professional aspects of health care: the osteopathic hospitals, the M.D. hospitals; and it brings out the demographic aspects of health care: the inner city hospitals, the urban hospitals, the suburban and the rural.

So, we are facing the whole spectrum, and I'm just exposing you to this because I think we're going to have to start the planning process at the top -- identify national goals and objectives, a blueprint, if you will -- with not too many specifics and then demographically flush that out in each State and in each municipality in this country.

To do otherwise, I think we are just going to wander around the issue, and I think we are making process in that direction, but it is going to take time, and as mentioned earlier, we are not going to do it overnight. But I think it is wonderful that we should be exposed like this.

I dream about this. I'll bet you I go to two meetings a week where we talk about these issues, and I find myself going in ever tightening circles because the options aren't many. But the course becomes clearer after a while, and I think we are all beginning to head in the right direction.

QUESTION: I'm fascinated with the quota on the four medical schools. From what does the planning process in Michigan draw its authority to impose those quotas?

MR. ALLEN: The public will, just the democratic process in Michigan as it is in the rest of this country. The only way you can express public will once you've got a plan is to get the public to endorse that plan, and then get legislation and other coercive aspects of the democratic process at work.

QUESTION: In other words, the quota system is not in effect at the moment?

MR. ALLEN: No.

QUESTION: It's recommended by the planning process?

MR. ALLEN: Right, and that, in turn, of course, translates itself into how much money do you subsidize these schools by to produce certain output.

MR. OSIGIAN: I'm Barry Osigian, from Pan American Life Insurance Company. I have heard a lot about planning today and some of it directs itself toward competition, which is a good idea to a certain degree. Too much competition, it has been admitted, might narrow the field down to a few giants and that wouldn't be good. We've talked about merging hospitals, which is going to attack, to some degree, the three percent administrative costs, but the 97 percent of the program outlays hasn't been approached at all.

Hospitals don't deliver medical care and contractors don't deliver medical care; physicians deliver medical care. I think we should be trying to figure out a way to engender some competition among physicians.

MR. COLLIER: Well, you have here at the table, in Mr. Fox, one of the world's leading experts on that topic and specifically on the issue of group practice, HMOs, et cetera, -- at least the first forum that we've hit upon for that.

MR. FOX: My own view of that is that in some sense I would agree with you that we do need to expand or to change, if you will, the kinds of competition among providers that now exists. You're right in that currently there is plenty of competition. Hospitals compete against each other to see who can get the latest technology; the payors, in some sense, compete against each other to see who can pay doctors the most, because any payor who isn't in that ball game is hurting the beneficiaries.

So, we have plenty of competition. The question in my mind is not the existence of competition, but the nature of the competition or, more broadly, the nature of the financial incentives.

One solution that has been advocated is promotion of prepaid group practices, HMOs or other forms of prepaid group practices. Personally, I'm all for it. I've been the lead for the administration in pushing for changes in the Medicare program for the way in which we reimburse HMOs -- but it is, at best, a very, very partial solution. We're going to have to learn to live with the present fee for service system and to modify it at the margin, and start to build in some combination of restraints and incentives into it.

I just do not see competition as it has been advocated by some, as anything approximating a cure all. I also believe that regulation and administrative measures work best when they are consistent with the financial incentives that exist. It is easier to divert a stream of water that is going downstream rather than trying to take that stream of water and make it go uphill. So, I don't view competition and regulation as necessarily contradictory.

One last point: not that planning should take place mostly at the top, but planning takes place best when the top -- and, by this, I frankly mean the Federal government -- establishes our environment, through the reimbursement system, in which it can take place. Many of us have been wrestling with the question of how to bring together reimbursement and planning, not that the Federal government will do the planning, but that we need to be less at variance with planning at the State and local level.

Let's face it, in some respects Medicare is a very good job creation program. At the local level, it may be more efficient to expand Medicare and Medicaid payments than it is to expand CETA, and we need to begin to look at how, through the Federal structure, we start to compliment the State and local structure so that the incentives are different. I view incentives, in some sense, as a broader word than competition.

MR. COLLIER: Well, I'll just take this opportunity to embroider on some other themes that didn't hit the floor. I want to come back, Barry, to a point that I thought you made in your question, with which I disagreed -- maybe I didn't make myself clear.

It seems to me that just as I agree with Peter that the HMO-IPA movement is a partial solution in terms of control of some undesirable aspects of physician practice, many of the institutional arrangements that we can encourage are similar devices for control. Let me just point to two.

I go back to the Buffalo General-Deaconess merger. The money that is being saved in that merger is being saved in a couple of ways. One is they are consolidating a number of services which both hospitals had which simply were duplicative.

That consolidation necessarily involves management control over physician practice in those institutions. It's a slow process, and so forth, but if you talk, as I'm sure many of you do, to some of the operational managers in the holding company or central corporate entities of some of the larger proprietary hospital chains, they don't feel, within limits, significant problems in disciplining physicians.

A third example, a major teaching hospital in New York City, under financial pressure, nothwithstanding a fairly large endowment, hired an administrator basically to put it on a sounder basis. He started, obviously, with the routine areas and got housekeeping in better shape, and purchasing, and all that sort of thing, but he then moved on to ancillary. He hired a couple of consulting firms to help him analyze physician practice patterns, particularly with respect to resident and intern practices; began a series of strictures with respect to test ordering by residents and interns, requiring supervising physician sign offs; forbidding certain things to be ordered by residents and interns, moving on again with something incremental, and so forth. I would suggest there is very much available to the administrator who has the proper backing in the proper environment.

I see that sort of thing happening. One of the more distinguished members of our audience said to me during the break that the decade of the 1980's is the decade in which the docs will give up. He may be right, I don't know, but it certainly will be a decade in which the lot of the doctor and the role is substantially altered, it seems to me.

Well, keeping you warmed up, I want to make one more point because it is just great to have this microphone and this audience, and these are important topics.

If you don't know much about long term care, learn about it. It is a matter of extreme importance, and it will be a matter of consuming importance in the future.

Now, most of you have been off the hook because Medicare doesn't buy very much of it. Medicaid buys it, so the leading experts in the room on that tend to be Paul Allen, because he runs a State program, and me because I used to run a State program and spent more than 50 percent of my time and, I can tell you, more than 50 percent of our budget on long term care, and a lot of things are happening there that will have, I think, significant implications.

For instance, there is, I think, going to be substantial pressure to end what in Medicaid has begun to be a fairly large fictionalization of the program. We now have in Medicaid, as you may know, the personal care option

in which Title XIX programs for health care services are being used for nonhealth care delivery, delivery of homemaker and other kinds of services. A number of our demonstration programs around the country have allowed, on a waiver basis, Medicare to pay for nonmedical activity delivered to beneficiaries.

The pressure is on now for that to be expanded significantly and for it to be expanded in a way that doesn't depend upon fictionalization, as I say, of XVIII and XIX. I think you can look for Packwood to introduce Title XXI shortly; Waxman and Pepper have already introduced the Community Services or Health Services Act in the last couple of months, and the drift of these things is to create substantial funding streams for the maintenance in the community, sometimes in institutions but more often in homes of individuals who are chronically impaired, typically elderly people, but who don't have health as their central problem; their central problem is just going along and doing what they need to do every day, having housing, food, some help in getting around and, when necessary, medical care, therapy and rehab services, and so forth.

I think a lot of the money for that activity will be reprogrammed out of XVIII and XIX, over time, and depending on how things go, we may have a role in that or we may not. We'll always be, I think, significant funding streams, but we'll certainly have to have some allied role in which we, either through devices such as channeling agencies or working through interweaving layers of administration, perhaps State governments, we'll have a role in this activity. Medicare is going to be more and more in it and you all are going to be more and more in it, and it is probably more than acute care going to be the issue for the 1980's for discussion.

And, so, I urge you to pay some attention. And there are a number of States doing some interesting things. Paul can elaborate, but they haven't added a nursing home bed in Michigan in five years, I think he told me, and they now have more people supported in community settings -- that is, non-institutional settings -- than they do in the institutions, with a variety of techniques which include supplementation of SSI, use of Title XIX monies, and so forth. These are things you need to know about, and I urge you to learn.

MR. WERNER: In the interest of stimulating a little more dialogue, there is one issue that I feel strongly about that hasn't been identified when we talk about what is going to happen to health care and its cost in the 1980's, and that comes under the very broad heading of health education and health prevention, what people can do to take care of themselves as contrasted to what the health establishment can do.

We have people abusing themselves with drugs and alcohol, etc. Are we spending enough of our valuable dollars for that aspect of health, or are we only in business to try to prove what most people think is true, that no matter what I do to myself, there is a great big medical establishment out there to correct the problem that I created, as contrasted with attacking the problem at home from the number 1 point of view.

MR. COLLIER: We are pushing this CHAP legislation very hard. It doesn't concern Medicare, obviously, because it has to do with children, but it is an interesting issue because it builds off the poorly functioning EPSDT program

to move into a somewhat broader and more administerable program. The purpose is to take a group for whom it seems expenditure on prevention would go a long way in terms of avoiding care later on. CHAP basically would provide what EPSDT does, but in a more elaborate way, for screening and diagnostic work and followup and therapeutic activity when necessary, but it emphasizes issues of catching people early, continuity of case development and case management, and again, not so much focusing on the back end of things, but making sure that people, at a time of great vulnerability (whether in the prenatal, immediate postbirth and then first early years of life), are screened and taken care of and brought back in on a regular basis for being checked.

At the other end of the spectrum, I think that it is just absolutely clear we have to get into that, but at the other end of the spectrum Roger Egeberg, who works with us and whose views I respect greatly, feels that the best prevention program for the elderly is continued activity, and it's not something that Medicare can very well address. I suspect that you will see more and more going on in that way, an attempt by society not so much to spend a lot of money on taking care of people who, through dint of inactivity, decline, but just trying to spend money to keep people out there for longer and longer. I hope that we will see that.

I must say, in the meantime, Ed and any of you who are here from Blue Cross, that it hurts me greatly to have to feign some medical problem in order to get my physical checkup paid for -- or pay for it myself -- and I welcome movement toward at least that much prevention.

MR. FOX: Let me just comment briefly, if I may. There probably are certain kinds of things that we can be doing in the preventive area that will, in fact, save money, and there is some empirical evidence -- a little wobbly, but nevertheless there -- that improved services for children will save money.

But I would like to state what I call Fox's law. Fox's law is that the death rate is one per person.

The implication of that is that people eventually get sick and they eventually die, and I would submit that prevention really should not be sold as an end in itself. Rather, it is to improve the quality of life or prolong it. But particularly when we get into the adult population, outside of a few things fairly simple like innoculations and maybe taking blood pressure, that there isn't a whole lot that can be done if the purpose is saving money.

NEW DIRECTIONS IN QUALITY OF OPERATIONS

Moderator:
Frederick J. Malley, Jr.
The Equitable Life Assurance Society of the U.S.

Panel Participants:

John Jansak
Office of Standards and Performance Evaluation, BPO, HCFA

John Berry
Office of Quality Control Programs, BQC, HCFA

Don Nicholson
Office of Program Validation, BQC, HCFA

Robert E. Rinehimer
Pennsylvania Blue Shield

Ken Schneider
Health Standards and Quality Bureau, HCFA, Region VI

William C. White, Jr.
The Prudential Insurance Company of America

MR. MALLEY: Our topic for discussion this morning is called "New Directions in the Quality of Operations." This presentation consists of three segments: one is performance standards, two is quality control, and three is the role of PSROs.

I'm surprised to see that we have such a good attendance this morning -- I think it constitutes proof beyond a shadow of a doubt of your undying dedication and loyalty and commitment to the Medicare program.

As to our panel for this morning -- you see we have a full table, not that we have less talent and are trying to overwhelm you with numbers; it's a talented group, that I can assure you, as you'll see for yourself in just a few moments, but it is because of the breadth of the subject matter that we are tackling this morning.

We have this panel broken down into what I like to refer to as four presenters and two responders. The four presenters will be John Jansak, who will be speaking on performance standards; Don Nicholson and John Berry, who will be talking on quality control; and Dr. Ken Schneider, who will be speaking about PSROs.

The two responders will be Bob Rinehimer and Bill White. They haven't had too much of a chance to prepare any comments in advance, since they won't know what the presenters are going to be talking about.

We'll be starting off in the order of the individuals I just acknowledged. At the end of each presentation, I will ask our two responders if they have any comments to make with respect to the subject that has just been covered.

I will, at the end of the four presentations, call on both Bob and Bill, to ask if they have any specific comments of their own that they would like to make.

When you get right down to it, we're dealing with meaty and heavy subject matter, but subject matter that is important and very critical to us as contractors and, in a large measure, may determine whether any of us remain in this program. It is in your own best interest, I feel, to find out what is being developed in these areas, particularly performance standards and quality appraisal, and if you have any doubts or questions, let's get them raised this morning. Bring them up while we have the experts here, and don't walk away saying you didn't have an opportunity to find out what was going to be done to you.

Rather than giving some background on each individual before he makes his presentation, I'd like to exercise the prerogative of the chair and very quickly give you a short rundown on each of the presenters.

Kicking off this morning on performance standards is John Jansak. John has been with the Department for 24 years. He presently serves as the director of the Office of Standards and Performance Evaluation. Of all of the gentlemen on the panel, John is the one that perhaps needs the least introduction. Anyone who has had the opportunity to go to Baltimore over the years, I'm sure has had occasion, for one reason or another, to meet with John.

John, in his present position, directs, as I said, the Office of Standards and Performance Evaluation, and this office is responsible for the development and implementation of State agency and contractor performance under both Titles XVIII and XIX of the Social Security Act.

John is a graduate of Brooklyn College and holds a Juris Doctor degree from the University of Maryland Law School.

The second presenter will be Don Nicholson, one of our pinchhitters, but a very able pinchhitter. Don is the director of the Office of Program Validation. He has been involved in various capacities in the health care financing field since 1967. He has had experience working in both Medicare and Medicaid and, for nearly two years, he worked in the Office of the Secretary of HEW. His experience also includes one year in the private sector where, I understand, he was in the executive interchange program with, I believe, Employers of Wausaw. There he was involved in industry marketing and managing of health maintenance organizations, a subject close to many of our hearts.

Don has been in his present capacity since 1977, where he manages a program designed to discover problems of Medicare and Medicaid program abuse. Don tells me that he is a graduate of a world renowned university called Transylvania University, and that everybody in the room would know where it is.

The next presenter will be John Berry. John is the acting director of the Office of Quality Control Programs. John has been with the Department for six years. During that six years, he has served in a variety of management positions, not the least of which was as director of Management Systems here in the Dallas regional office, working with State agencies as a consultant on management problems.

He, too, was a participant in the President's Executive Exchange Program, and in that capacity was involved with financial analysis in the private sector. Most recently, he has been involved with Medicaid and now Medicare quality control programs with responsibility for design and operation of formal quality control programs covering both payments and service delivery. John is a graduate of Northern Illinois University.

The last of the presenters is Dr. Kenneth C. Schneider. Dr. Schneider is a graduate of St. Peter's College in New Jersey. He is also a graduate of the New Jersey College of Medicine and Dentistry and a graduate of the Tulane School of Public Health and Tropical Medicine.

He presently serves as director of the Office of Health Standards and Quality for HCFA in Region VI, which is the Dallas region, and he has served in that capacity since 1977. A very active young doctor, he also serves as an adjunct associate professor for the Department of Health Service Administration at Tulane University School of Public Health and Tropical Medicine in New Orleans, and clinical assistant professor in Environmental and Community Health at the University of Texas Southwestern Medical School in Dallas.

Dr. Schneider has a number of memberships; among them are memberships in the American Medical Association, the American Public Health Association, the

American College of Preventive Medicine, and the American Academy of Family Physicians. He is licensed to practice medicine in three States: Texas, New Jersey and Louisiana.

Turning now to my two cohorts from the private sector: Bob Rinehimer, who, since 1970, has been the president of the Pennsylvania Blue Shield, which is the nation's largest Blue Shield plan. In addition to his responsibilities at Pennsylvania Blue Shield, Bob serves as vice-chairman of the Board of Directors of the National Blue Shield Association, as well as serving on its executive committee.

He is a prominent spokesman, nationally, in the health care field, and was one of two representatives from the insurance business -- the other being Morton Miller, from my company -- who were appointed by the former Secretary of HEW, Joe Califano, to serve on a member advisory council that conducted far reaching inquiries into the problems of financing health care services in the United States and Canada. As I recall, the name of that group was the Advisory Committee on National Health Insurance Issues.

Bob is a graduate of Lafayette College. He did graduate work at the University of Pennsylvania, and also at the University of Michigan and Syracuse University.

Last, but far from least, is my associate of many years, Bill White. Bill White became (in 1973) vice-president in charge of the Prudential Insurance Company's Governmental Health Programs Office, headquartered in Millville, New Jersey. In that capacity, Bill is responsible for the administration of Parts A and B of Medicare in New Jersey, Part B in North Carolina and Georgia, as well as Prudential's administration of a major part of New Jersey's Medicaid program. Bill is graduate of Milliken University and also did graduate work at the Illinois Institute of Technology and the University of Chicago.

I hope Bill will forgive me for mentioning that he is one of those that we in the commercial end of the business feel we have salvaged, because before joining the Prudential in 1958, he served in management positions with the Wisconsin Physicians' Service and also the Illinois Blue Cross/Blue Shield plan. Bill is one of the vanishing breed (of which I also happen to be a member) in that Bill was one that was asked, back in 1965, by the Social Security Administration, to serve as a member of one of the advisory task forces to assist in the implementation of the Medicare law. These task forces developed all of the original rules and operating instructions for the Medicare program which, as we all know, began on July 1, 1966. Bill has also served as a member of the Secretary of Health, Education and Welfare's task force on Medicaid and related programs.

We'll be starting off with the first subject -- performance standards, handled by John Jansak. As I said earlier, this is an area that I think many of us, over the years, have all seen a need for, perhaps even dating back prior to the recommendations made by the Perkins Committee in the mid 1970's. Our only concern with respect to performance standards in the past -- and I feel that concern still exists today -- is that we want to make sure that the standards are realistic and meaningful.

As we all know, we now have standards that have been developed for Part A. The standards for Part B are well along in their development, and these standards could have a very dramatic impact on us and our future in this program, as contractors.

I will now turn to John to give us an update on where we stand with respect to the A standards, the B standards, and anything else that he might want to enlighten us on.

MR. JANSAK: Today, in talking about standards, in particular I would like to talk about where we are going, but first I would like to talk about where we came from, the background, some of our rationale and why we made the decisions that we did.

In contractor and performance reviews, I think it is important to understand our responsibilities to Congress, how to explain how the program money is being spent, are the taxpayers getting their bang for the buck, is the program running efficiently? So, we are always looking to Congress on what we are hearing from GAO, because that's who we have to respond to.

On the issue of public accountability, that has driven and will continue to drive us in our various endeavors and particularly standards performance evaluation. It also drives us, on a parallel track, concerning contract experimentation. That is, can we do things more efficiently for the taxpayer? The evolution of the process -- we started out early in the program with central office reviews, usually of a snapshot or team visit into a contractor's site. This provided certain expertise out of a one train group, but did not provide a continuity of review, and that was very critical to the evaluation process.

Over the years, we shifted to providing regional support for the reviews. The reviews shifted from a snapshot to a look at the contractor through the whole year of operation. The on-site representatives were put in place to provide continuing dialogue between the program and the contractor, and the phase shifted from just a quick look to a long, continuum of evaluation. This we have kept in place today.

Also, out of this procedure we developed the annual contract evaluation report, which is, in effect, a report not of a point in time, but of the contractor's performance during the year.

Despite these shifts, we continued to hear complaints from various parties. Fred mentioned the Perkins Committee report. There were various points made by Congress, GAO, the contractors. There was an allusion made yesterday to the PMIC report to the same points; that is, there are variations in the performance standards required by the ten regions and there are also variations in the review process.

I think the ACER process, in the past, has worked quite effectively, but there is some variation because of the extent and size of the country.

Another way you can see this problem is in the AJJ issues that have been raised by the same group of people; on a macro scale, we were told to have more national uniformity of procedures and process, and on a micro scale, we had problems of different intermediary judgments regarding coverage or reimbursement within individual States.

This leads us to our current process of establishing national standards for performance evaluation, and that provides also for a structured review process. Our current concept is essentially of two tiers; performance criteria and statistical standards.

Performance criteria does assure basic program requirements are being carried out at an acceptable level. It is process oriented, but it is also oriented at assuring that the level of performance is equivalent in all contractor sites. It is also an opportunity for us to expand in the future and have better controls on program payout, not just the three percent administrative expense that we've been talking about, but the 97 percent of program payout.

In a number of areas in claims processing and coverage, we've made some initial steps looking at program payout. One of the most important things we can do in the future is to look at how the criteria can help us control program payout; using the best ideas in terms of quality control, pre and postpayment screens, putting all these ideas together will be one of our future initiatives in terms of criteria, not only to control the operational policy, but also to look at the overall program.

The statistical standards are quite a bit simpler to understand. They relate to processing time, to quality from the Part A CREP's cost, or from the Part B end of line. They also, of course, have the unit costs.

Those of you who possibly are not familiar with them; both criteria and statistical standards have points above and below certain cutoffs, which provide an array vertically of superior performers and less than adequate performers.

The essential features we see of both criteria and those standards, are that its results are product oriented rather than process oriented. For example, on interim payments, we provide a certain standard of performance, within plus or minus seven percent of the target. We do not look at how the intermediary, for example, establishes interim rates.

Second, we believe the standards should be objective and quantifiable. Third, they should be uniformly applied throughout the country. Fourth, the statistical standards are adjusted for noncontrollable variables affecting unit cost per claim, such as the volume, the mix, and the geographical wage differences. This is an attempt to level out the differences in the contractor's environment that he cannot control, and to take out especially those important elements.

We also have a new feature which we have used in the past reviews, but have now incorporated in not only Medicare Part A and Part B, but on the Medicaid side; that is, statistically valid sampling methods and techniques. This is probably the most difficult problem for the regions to do. It is hard to get the samples in many cases. It is also very time consuming. But, in effect, it is the heart of the criteria process if the sample is derived in an objective way and, in fact, takes a review three or four periods of time over the entire operation during that year.

Sixth, the entire program is issued to contractors before (when the standards are issued) the period begins. That is, up front, you know the

program, you have the manuals, you know the sampling techniques that we use, you know what the percentiles will be, the targets for the upcoming year; therefore, you, the contractor, can in your own quality control environments, maintain your standards at whatever level you decide to do.

Seventh, and probably of most importance to us as a major objective in the future, not to utilize the standards as a minimum cutoff point, but to use the point systems that we can provide to rank the contractors and provide, in particular, bonus points to show the better than average performers.

We feel this will be an incentive for good performance and will drive the contractors forward, and together with the fact that it is up front, allows a very fair assessment of contractor performance.

The expectations for 1981, I think you know -- Fred touched on the fact that the Part A standards are out and the Part B standards are in process now -- we'll begin consulting with the regions to make requirements, based on their findings this year under the A program and the field tests under B; we'll also be talking with the contractor work groups in refining the packages for 1981. This will probably occur in June. Both the revised fiscal year 1981 packages would be issued before October 1st of this year. I say it is important because the substantial contributions have been made by the contractor work groups and they have aided us greatly in developing these standards. But we rely on your knowledge and that of the ROs in carrying out this package.

In the central office, we are not the experts on these reviews; it's the regional people and the contractors who know their operation and the techniques that we can use.

At this point, I would like to thank each and every one of your organizations for the help and contributions. It has really made this work out much more easily than we expected, and I think it will work out fairly to both sides in this process.

I'd like to describe how much conversation there has been on standards among the contractors alone, as between the various work groups, TAG, FIG or CRG meetings. On Part A, for example, we've had at least nine meetings in the last year or two, five in 1978 and four in 1979. On Part B, we've had eight meetings; six in 1979 and two this year.

This leads me to say that these meetings will not end; that we view the standards process as an evolutionary one, and that this dialogue, we hope, will continue. It's done at the working level, by and large, very effectively by knowledgeable technical people who have put a lot of time and spirit into the process, and I say this because of those standards that you see before you now that you have a problem with, unworkable standards will be eliminated and problem standards will be revised, and we'll come up with new ideas and techniques.

We hope the B process is better than the A. We hope the Medicaid standards are better than the A and B, and we'll just rotate them to improve each in their particular perspective.

One of the results of a standard process and point system is that we have an opportunity to fairly rank contractors. We are now working on methods of ranking performance on the both A and B, though, of course, the A is a little more progressed on both the criteria and statistical standards.

This essentially involves a weighting of various criteria, point systems and other mechanics which you will see eventually. We are just now drafting it, but we do hope that the process allows this to be somewhat more objective and more precise than in the future.

The ACER process will also be objective and rely in large part upon the standard finding in the sampling techniques. There will be opportunity for the regions to comment on various areas of problems they have found that are outside the standards since the standards cannot encompass each and every activity. It also provides comment on the Part A side, for example for looking at a coverage process. We're also providing opportunity to look at HHAs as opposed to hospitals and as opposed to SNFs.

Hospitals, for example, are 96 or 98 percent of the workload or dollars, in most cases, but we don't want problems, like in the HHA area, to fester and yet be covered up by an overall satisfactory with a hospital coverage review.

We also intend that for the experiments we do in the future, to the extent possible, the standards will be part and parcel of the experiment. I think John Thompson mentioned yesterday the fact that in Maine we use the 60th percentile. It is an important philosophical question for us to decide in experiments, in particular, what level of performance can be expected of an experimental contractor. Should it be less than the rest of the community, should it be average, or should it be higher?

That is an interesting point of contention. It has something to do with the price we receive, of course, but we do want high quality out of experimental contractors, as well as anyone else.

MR. WHITE: Well, I guess, just an old chestnut that I've raised before, and that is the male professional salary index of 1969. Isn't there anything better than that, John, available?

MR. JANSAK: A number of items were tested, female indexes, male indexes; the thought turned out, by the various statistical analyses, that was the best one available. We will try to get something that is more current, but it did test out to have the most influence, strangely enough. It has something to do with minimum wage levels throughout the country, which affect most of the work force, which reduces the differences and then the major differences are, in fact, a reflection of professional salaries.

Probably in the future, a professional index composing both male and female probably will turn out to be the most accurate reflection on the locality. But I think the minimum wage levels is what flattens that out to some degree.

If anybody has any ideas, we'd be glad to have them brought to our attention; we just haven't found what is more appropriate yet.

MR. RINEHIMER: Mr. Chairman, I'd like to come at performance standards perhaps from a different perspective. Being a Pennsylvania Dutchman, I guess I can tell the story, although I'm told that an ethnic story should not be told from the platform.

There was a city dweller driving through the countryside where the Amish are located, and he got lost. He hailed a farmer and said, "Hey, farmer, where does this road go?" The Amishman said, "I don't know." The driver then said, "Well, where would I go if I went back the same way I came from?" The Amishman responded, "Well, I don't know which way you came from." The city dweller then inquired, "Do you know where this road goes?," to which the Amishman responded, "Well, I've lived here forty years and it hasn't gone any place." Then this city slicker said, "Well, you're the dumbest, stupidest Amishman I ever did see." And the Amishman shot back, "Yes, but I'm not the one who is lost."

Now, listening yesterday to the conversations, the discussions, and to what John presented this morning, I just hope we don't get the feeling that either HCFA or the contractors are lost. Sometimes it becomes mind boggling to me. In the early days, I remember, we were told to pay the damn claims and if we needed more money, we could get it. Well, we all recognized that sooner or later things would change, and they have.

I think the development of the performance standards is the result of a natural evolutionary process. I'm glad to see that. We talked about competition yesterday and contracting strategies. We talked about competition among the providers, and so on, and yet, it seems to me that the performance standards would be one way to really develop competition. I think that's a sound way, providing that the standards are well designed and implemented.

I was also glad to hear John say that there is a dialogue that is taking place. It will have to become more so as the program becomes more sophisticated.

Now, let me personalize this a little bit from the human equation.

These performance standards don't mean anything unless you make your colleagues and employees aware of them. It takes a good communication process at home to make sure they understand what you have to do and what the climate is.

There can be inconsistent reporting. Now, true, we are making progress to reduce that but, for that very reason, I think that we must look to compete with ourselves.

What do I mean by that? In my operation I have said to our folks, "Don't worry too much about comparing yourselves with the others, according to these reports. There are differences in there and you may be comparing apples with oranges."

So, I think one of the best things to do is to have these standards lead to a critical self evaluation of our own operations. Let's look at our current operations versus historical and versus what is anticipated in the future. I think those are important.

And, finally, I'd like to say this: even though we are making this progress toward performance standards, I still think we'll have a fundamental problem always existing. I think that you will always be debating how you strike a balance between administrative costs and program costs.

I know we have statistical standards where you can measure, quantify, and so forth. However, now we're moving into areas that you can't quantify very well -- like utilization safeguards, coverage safeguards, reimbursement methodology, professional relations, and beneficiary services.

What is the optimum level of service that you are going to offer? How do you balance, especially when you're thinking of competition, between administrative costs and total program costs?

This takes judgment, and I'd like to make this analogy -- I'll defer to Dr. Schneider on this: I think the medical profession has lost something, maybe too much reliance on advanced medical technology, numerous tests and so forth, foresaking judgment and the laying on of hands. I say to all of you, and to HCFA, let's not lose sight of our main mission; let's not become bogged down in the compliance with performance standards, per se, to the disadvantage or to the detriment of service to the beneficiaries and providers.

In the last analysis, regardless of performance standards, I have the conviction that we must ultimately rely on good, sound, downright management to achieve cost effectiveness and to provide good service to our beneficiaries and subscribers.

MR. NICHOLSON: I'd like to cover two areas. I'd like to describe in some detail the validation activity that we're involved in, which is reflected in the program validation annual audit plan, but before I do that, wear the Marty Kappert cap and give you an overview of what the Bureau of Quality Control is all about.

The Bureau of Quality Control is new within the HCFA configuration, having been created with the most recent reorganization that we went through last spring, and I'm afraid, not terribly well understood; so if you will bear with me for a minute or two, I'll give you a brief overview of what the Bureau is and what it is intended to accomplish.

We are organized into four major boxes, and two of those boxes are represented here this morning by myself, responsible for the Office of Program Validation, and John Berry, responsible for the Office of Quality Control Programs. There are two other boxes called the Office of Systems Analysis and the Office of Financial Analysis.

The Office of Financial Analysis has two primary responsibilities, one being on the receiving end of external audit reports (HEW and GAO audit reports, primarily), and represent HCFA in assuring that there is a timely and proper response to external audit findings and recommendations. That's not to say that we, in the Bureau of Quality Control, are responsible for responding to all of those audits, but we do respond to the extent that it is an area that we're responsible for and we do coordinate HCFA's responses.

The Office of Financial Analysis is also responsible for doing analysis of statistical information to plot trends in program payments, and to raise questions as to why those trends are looking the way they are. Much of what Mr. Schaeffer indicated yesterday when he was talking about the necessity to build better, more accurate and more complete data bases is necessary in order for the Office of Financial Analysis to function in the way that is really intended within HCFA.

The Office of Systems Analysis has varied responsibilities. One of the things that they do that is of particular interest, as far as my operation is concerned within the Bureau, is use software programs and computer capabilities to array and rearrange data in a way so that lead information specific to problems in particular program areas or problems with regard to particular providers can be identified; so that information can be conveyed to the intermediary of the State Medicaid agency; so that we, ourselves, within the Bureau of Quality Control, might initiate some specialized audit activity.

Two of the four offices in the Bureau are Systems Analysis and Financial Analysis. Of course, John and I will talk about program validation and QC programs which are the two remaining offices and the ones we have specific responsibility for. A major function of the Office of Program Validation is the conduct of validation reviews both by central office staff and staff we relate to in the regions. The function is relatively new. We conceptualized what we thought program validation should become, for the most part in 1978. Last year, 1979, we spent a lot of time doing validation reviews. Although we did have instructions and were communicating back and forth between the central office and the regional offices in terms of what we wanted to do and how we wanted to do it, we were operating in a test mode.

We decided that it was important for us in HCFA to try to figure out ways to become a little more proactive than perhaps we had been before, in terms of identifying and dealing with situations of fraud, abuse, and waste in Medicare and Medicaid programs. We also thought it was necessary to perhaps do more than had been done in the past to try to forge together some of the systems that were in place between Medicare and Medicaid to identify fraud, and control abuse and waste.

It was to meet these objectives that we developed the validation review approach. The process breaks into three major component parts. One is related to institutional providers, which we call aberrant cost studies. What it consists of is simply taking information, statistical or other information which indicates that there is a potential problem with regard to a home health agency, a nursing home or a hospital, and then doing an investigative type audit to learn whether or not those statistics are truly indicative of a problem.

Actually, in doing those reviews, a two pronged approach is involved, one prong being to look at costs and whether or not costs as reported and used as a basis for program reimbursement are accurately reported, or whether or not there might be some abuse associated with the way those costs are reported. The other prong would be to look at medical issues, try to examine the medical necessity overutilization possibilities with regard to individual providers.

The second form of program validation review we call systematic abuse reviews, very similar in many respects to the institutional type review that I just described, except that it relates to noninstitutional, ambulatory care providers.

Here the approach is one of taking a grouping, if you will, of somewhere in the neighborhood of 10 to 20 of a particular provider type in a particular geographical area, DME suppliers, ambulance companies, psychiatrists, podiatrists, etc., and examining again through a designed review protocol what those individual providers are doing in billing Medicare and Medicaid, to verify that these dollars are being paid appropriately.

The third aspect of program validation we call program implementation reviews, an area that we're particularly excited about. With program implementation reviews, we are not really looking so much at individual providers; rather, we are looking at program areas: is it right the way that we have reimbursed hospital based physicians over the years under Medicare or Medicaid? Let's go out and do a survey in X number of facilities to take a look at this specific area of program reimbursement. This is just one example of a subject area that could constitute a program implementation review. We pick out an area where we think there is a potential for some vulnerability, either on the part of Medicare, Medicaid or both, and examine that area in some pretty tight detail so that we can come up with policy recommendations, or recommendations otherwise, to assure more appropriate expenditure of program dollars. It may be necessary, on the basis of the results of that review, to come in with a recommendation for legislative change, for new regulations, for guidelines, whatever.

So, those are the three aspects of program validation and, just to summarize briefly, the three review areas are aberrant cost studies (institutional providers), systematic abuse reviews (noninstitutional providers) and program implementation reviews to look at particular areas of program reimbursement to discover what impact it is having on the program.

So far, through December 1979, we conducted 80 reviews of the various types. We haven't gotten all of these 80 reports in final, but we do have all of those reviews at least in draft form, and we have several of them in final report form. As a result of those reviews, we have identified $43-45 million of either overpayments or potential savings to Medicare/Medicaid as a result of the recommendations that we came up with.

Last fall we called in each of our regional offices and spent half day sessions discussing what we thought our fiscal 1980 activity ought to be in the area of program validation. As a result of those discussions, we produced a draft audit plan which was circulated in October. On the basis of feedback comments, we put that plan in final in February. We will be sending out the audit plan via an intermediary letter, hopefully within the next few weeks.

A couple of things that we're concerned about with regard to our own activity in the validation area, and something I think bears a relationship to the contractors with regard to activities that they have in a similar vein, is focused audit. I believe it is critical in the course of doing claims review and audit to gear that activity toward those providers which potentially represent the greatest problem. I know that this initiative on

the part of some of our regional administrators is to work with intermediaries, to work with State Medicaid agencies, so that, particularly in the audit area, more time, more attention, can be paid to those providers that, historically, have represented the greatest problem.

Another area that we're concerned about is medical review and peer review. Much of what we get involved in doing these validation reviews, and I'm sure that you get involved in where you have providers that represent a problem for you, are problems of unnecessary services, overutilization. There must be a good capacity through Medicaid expertise to adjudicate these issues.

I would like to ask you all to be on the lookout for that validation audit plan when it comes out; we would like to solicit you, as partners along with the State Medicaid agencies, in carrying out the design of the validation review activity. We believe that it's a pretty good tool for giving us an opportunity not only to discover problems with regard to an individual provider, but perhaps even more importantly, to discover and document problems associated with specific areas of program reimbursement, so that the necessary steps toward resolving these problems can be carried out.

MR. BERRY: Following on the theme we talked about yesterday, a limit on the amount of program dollars that are going to be available to spend for our beneficiaries, I think one of the prime functions of the Office of Quality Control Programs is to conserve these funds by assuring that they are spent correctly.

In terms of the programs that we operate, we define "correctly" as to an eligible beneficiary for a covered service within allowable cost or fee schedules, and not a duplicate of a claim that has already been paid.

To carry out this mission, we operate or design uniform national quality control programs that examine specific aspects of payment or service, with the objective in mind of sitting outside the normal policy and operational process and, from being outside that process, be able to provide an objective opinion about how the process is operating.

Programmatically, within Medicaid, we operate a quality control program that looks at eligibility, that looks at the claims payment process, and that determines whether States recover from third parties before they spend Medicaid funds.

We also operate a utilization control program that looks at the way States operate utilization control within long term care facilities. And we operate a program called Early and Periodic Screening, Diagnosis and Treatment Quality Control that assures that children in public assistance families receive required screening and medical treatment.

Within Medicare, we currently operate two quality control programs: the cost report settlement process that examines the intermediary operation, called CREP, and the claims payment process review of carriers, called Part B end of line.

The outcomes of these reviews in both Medicaid and Medicare are our choice -- a point that I would like to stress; quality control produces data, and what we do with that data is up to us. We think the data should be a catalyst for program improvement, and we think there are at least three areas of program improvement that we can concentrate on with this data that we produce out of quality control.

The first is within HCFA. Are the HCFA policies and regulations clear, unambiguous? Do we set out a clear standard of performance for people to follow?

Secondly, do we provide enough money to properly audit providers? I know that has been a question or issue, and I think that is something that the Cost Report Evaluation Program will begin to delve into.

And, thirdly, you get into the operational details themselves. Are the contractors properly carrying out the program the way it is written?

All three of these aspects are examined by the uniform national quality control programs that we operate.

We think that the bottom line of a quality control program has got to be program improvement. That's where quality control has to show up. It's an expensive operation, it's expensive in terms of direct labor costs, it's expensive in terms of the management time that is required to look at the issues that quality control brings up. We think that we are measured, then, by the program improvements that we can cause to happen with the data that we produce.

The systems we operate aren't perfect. We spend a lot of time on self evaluation and improvement. One of the problems that I'm sure you are aware of, and we are certainly aware of, is national uniformity: are we running these programs the same across the country, so when we sit down and compare intermediaries or compare carriers, one to another, are we comparing them on the same basis?

The resolution of disagreements; do we have a fair way to listen to the opinion of the people that we've evaluated and make sure that opinion is considered when we develop our data and reports?

The size of the samples have been an issue, particularly in Part B end of line, and we have the same issues with the States on that side of the house. Are we sampling too big, spending too much labor on the sample size? Is the sample size too small so that we can't produce a valid estimate of error across the country?

And, lastly, the subjectivity of the cost report evaluation process. Can you ever run a process like this that does provide a uniform national comparison of intermediaries, or is the nature of the process always going to be too subjective for this to be carried out?

We see our relationship with operations something like this. Quality control programs produce data. We, in the Office of Quality Control Programs, participate in the analysis of this data, looking for what problem situations

may be there, what the causes of these problem situations could be, and the data that flows from us to you and to the Bureau of Program Operations and the Bureau of Program Policy within HCFA -- it's up to you and it's up to the operational side of HCFA to plan whatever corrective action program improvements may be appropriate. Then Quality Control steps back in the loop again with another measurement period to look at the effectiveness of these corrective actions.

The future directions -- three or four points I'd like to emphasize where we see these quality control programs going.

First, one of our strengths is also a weakness. We run a uniform national program across the board in both Medicaid and Medicare, but the uniform national program doesn't give us the ability to target well enough sometimes. We want to look at pulling back a little bit on the uniform national review, reducing the sample sizes on a national basis, and try to concentrate on specific program areas or specific contractors where the data indicates there is a bigger problem than in other areas. That's one direction we are going to try and bend these programs in.

The second thing we're going to try and do is widen the family of providers we look at in the cost report evaluation program. In FY 1981 we are going to have a cost report review for HHAs, and we're going to extend the CREP program in Medicaid.

We're also going to try and move the CREP program up on a more real time basis and determine if we can look at the interim rate setting process through CREP. I don't know whether that is possible or not, but it is something we are going to consider. We are also going to try and provide a better analytical software package on the B side of the house to make the Part B end of line data more readable for a manager, and shorten the length of the printouts that we produce.

Another objective we are pressing for is to keep the learning up between Medicaid and Medicare. Along those lines, we've changed the error rate definition in the Medicaid claims processing review to conform to the definition we used in Medicare. Medicare has had a lot more experience in these quality control programs than we had on the Medicaid side of the house, and we have been able to use that experience quite successfully to redesign and improve some of our Medicaid QC programs.

Similarly, as I mentioned, we want to extend the cost report evaluation process into Medicaid. This has never happened in the Medicaid programs, where there has been a controlled, comprehensive, Federal review of the way that the States carry out their responsibilities in settling provider cost reports.

Last, and maybe my personal favorite, we want to improve the analytical capability in the Bureau of Quality Control where we don't produce just data dumps, we produce information that helps to focus where the problems in program management may be. By focusing on those problems, maybe we can come up with some solutions that can be applied on the operational side of the house.

We've taken two efforts this year to go in that direction. We ran the CREP program out last year, in FY 1979, but we don't plan now to publish the results of that review because the review wasn't complete. I think it would be misleading to publish statistics that compared intermediaries on the basis of less than complete results. But we did have enough data to go out to our regional offices with the ten worst performing intermediaries on the basis of last year's CREP. We've asked the regional administrators to come back to us and suggest what we could do with this data in hand now, how we can use the data from the 1979 review to better focus the 1980 and 1981 reviews, and to come up with program improvements or corrective action on the part A side.

Similarly, in Part B, the quarterly report that just went to the printer focuses Part B, for the first time, on the ten best and ten worst performing carriers. One interesting piece of analysis that came out of that is, on the basis of the data that we've got in hand, the ten best performing carriers in terms of error rate have been the best performing carriers for some time, and they are getting better; the ten worst performing carriers have been the worst performing carriers for some time and they are getting worse. Their error rates are increasing.

Now, that's an interesting piece of analysis that leads to further analysis. We are asking our regional administrators to look into that and comment. Is this a fair evaluation? If it is a fair evaluation, what can we do to exchange practices between the best and the worst where maybe we can bring them up?

In all the reports that we publish from the Bureau in the future, we do want to stress the analytical usefulness, the strength of this data, for planning program improvement.

In summary, we produce data that has integrity and is reliable. We're going to press to see this data used for program improvement, not just end up on a bookshelf some place. We want to listen to you about how we can improve this measurement process, make it as useful to you as it possibly can be, and how we can improve this analytical effort that we are just now beginning. So, our ears are open and we are glad to listen to comments now, or at any time, about these uniform national quality control programs that we operate.

MR. WHITE: On CREP, you said you welcome comments; I have some.

First, I have a feeling that my own audit people may be taking some steps in the future that, in their own good judgment as auditors, they wouldn't take except for the fact they feel if they take those extra steps, which cost money, they might make a better score on CREP.

And, secondly, in the questions that are raised during that CREP review, in looking through the questions, to me, obviously some are a lot more important than others. Yet there is no weighting on the questions as to monetary value of whether you did this or did that. It seems to me, as you go down the road, perhaps there ought to be some kind of weighting in scoring points on that questionnaire.

MR. BERRY: I think that's a good point and something that has concerned us, and that we are taking a look at. We plan on contracting this year with

the American Institute of Certified Public Accountants to take a look at the CREP program and give us their opinion as to how it could be improved. I'm sure that weighting issue will be one thing that comes back.

We'd be willing to share that review when it is complete, because we want to be very open and above board as to how these programs are operated. We thought that would be a good objective source to go to for that kind of information.

As far as causing a contractor to do something for the sole purpose of scoring well on CREP, but that is something that would not be a good business practice to do, from your viewpoint or our viewpoint, I don't think that should occur. And if that is occurring, we sure would like to know about it because we'd like to change those questions.

MR. WHITE: I think we'll all have to watch that, because I think that is a danger that the people looking forward to the next review are going to say, "Well, I really don't need to take this step in the audit procedure, but I'd better do it to protect myself in order to get a good score." And that costs money.

MR. RINEHIMER: Don, on your system abuse or fraud review of the aberrant practices, and so forth; in your design and implementation of these validation programs, did you seek much input from the intermediaries or carriers? It seems to me what you have described many of the intermediaries and carriers had already been doing, either in their private business, for government, or for both, and I wonder whether there was some duplication of effort.

MR. NICHOLSON: Yes. I think those parts of the validation process, in at least some measure, are a duplication of what carrier and intermediary responsibilities truly are, and I think at some point -- and I'm not exactly sure when the point comes -- we'll probably want to back out of that activity altogether.

It was felt, at least in part, because we are trying to build something uniform or at least in some measure more consistent between Medicare and Medicaid, that we ought to throw ourselves into the fray a little bit. We'll be selective -- we're not talking about a large number of providers out of the total universe. And certainly in no way should anything that we are doing under the rubric of program validation displace or replace any of the intermediary or carrier activities or State Medicaid activities that are an ongoing part of the process right now.

We had some informal discussions. I'll have to say that we never presented validation as a concept or any of the language behind validation formally to the CRG groups or the FIG groups or the other advisory groups. However, as we are getting involved now -- and, as I indicated, now that we are sending it out with an intermediary letter -- we welcome any reaction that any of you have in terms of what we have structured as a plan, so that we can modify or change it as the need arises.

MR. RINEHIMER: On these quality review programs, some of the States that administer Medicaid programs have some wonderful reputations for quality and if they don't perform, are you going to hold their money back?

MR. NICHOLSON: The issue of sanctions or disallowances on Medicaid quality control was an issue that was taken out of our hands by the Congress with the so called Michel Amendment, that does set a performance standard for State agencies to follow and does legislate that we disallow Federal matching funds over the standard.

I think there is a message in that for us, that the Congress was quite upset with the management of the Medicaid program and has dictated to us, both in utilization control -- which is an extremely rigid fiscal sanction, and in Medicaid quality control -- which has a little more leeway in its sanctions, that they are serious about getting control on misspent money, and have really taken away a lot of our flexibility on how we would use quality control data.

DR. SCHNEIDER: Our theme is measurement standards of performance under contracts, and certainly it is focusing our attention on what constitutes the contractual obligation. I am reminded of a cartoon I saw. The setting was a suburban kitchen, and there was a gentleman in coveralls, down on his hands and knees, and on his back was "Ajax Pest Control Service." He had all the little tools of his trade, the cannister and the little hose, and he was down on his hands and knees, but the focus of his attention -- in front of him, on the floor, were these lines and lines of little creepy-crawlers, little insects. They were arranged very neatly in files and in platoons. The little end bugs carried a pennant and there was a color guard.

And in the background was a very harried looking housewife. The caption was, "Ma'am, you should have read your contract. It said we'd control them; it sure didn't say anything about killing them."

I'd like to briefly talk about the general direction the PSRO program is taking, give you an implementation update, and then get into some of the areas that will be of primary interest to you.

As to implementation, this fiscal year PSROs plan to review 11.1 million Federal admissions. This is 70 percent of the total of about 15.8 million that would be potentially subject to PSRO review. Sixty-seven percent of the reviews will be Medicare reviews, so that now PSRO review covers 4,699 hospitals out of the 5,525 that are located in conditional PSRO areas; 73 percent of our nation's 6,500 hospitals are now under PSRO review.

As you know, most of the Federal programs have been hard hit by budget cuts, and the PSRO program certainly has been among them. So many of the major initiatives that the PSRO program is undergoing relate to a much more determined effort to manage the program to get the job done the best way with the limited funds that are available.

A number of the initiatives began during the past twelve months, and there are a number that are now in place. We can begin to see some of the results. Let me enumerate. First of all, focused review, which means placing more emphasis upon particular diagnoses, procedures, hospitals, and physicians where the PSROs identify problems. Most of the PSROs are into

intense review of less than 50 percent of their cases, and in the belief that since data systems are now in place, it is no longer cost effective for PSROs to look at a hundred percent of the admissions.

Another initiative would be the provision of incentives, rewarding PSROs that have demonstrated an ability to perform well by supplementing their budgets with additional funds to conduct special initiatives in such areas as ancillary services review. PSROs that have performed poorly do face the loss of Federal funds if their problems aren't corrected and, in fact, to date, we have discontinued support of six PSROs. This extreme action of defunding sometimes is necessary and it has to be taken in some cases, but our goal is improvement rather than punishment.

Now that the PSROs recognize that nonrenewal of their grants is a very serious possibility, we're finding that those PSROs that get into trouble are much more willing to work with us to resolve their problems.

A third initiative is in the area of PSRO objective setting. If we are going to assess the quality of PSRO performance and insure cost effectiveness, we need performance indicators to measure PSRO performance. Merely going through the process of review, as we emphasized in the beginning of the program, is no longer good enough. Each PSRO now is required to work with its regional office and to negotiate realistic, quantifiable objectives that are based upon the particular nature of the utilization and the quality problems in the PSRO area.

The objectives that are set by the PSROs have ranged from reduction in long preoperative stays, for some specific procedures, to improvement in the inappropriate use of emergency rooms and increase in the use of outpatient settings for surgery.

Along with this local objective setting process, we'll soon be asking PSROs to begin meeting national goals. PSROs are going to be expected to focus upon perceived national problems and, where they exist locally, to incorporate them in their local objectives.

Now, a fourth major initiative the program has taken in terms of cost reduction is budget control. When the PSRO review budgets were reduced, we had to provide special assistance in financial management, and we developed models that showed how review costs might be structured to achieve necessary reductions. Also, regulations were developed and are now being finalized, which allow PSROs to control the costs not only of their nondelegated review, but also of delegated review in hospitals.

By the end of 1979, the cost of review averaged $8.70 as opposed to the average cost back in 1977 of $13.00 per review.

Now, the reduced program budget really hasn't changed the review responsibilities that the law requires of PSROs, but it has made us take a hard look at how we can most effectively accomplish that review which still remains to be implemented, and we think that the best way to do this is by building upon and strengthening the existing systems that we have, not by duplicating or reinventing.

So, since the PSRO program and the Medicare program are now both under HCFA, Leonard Schaeffer and Dr. Helen Smits, our Bureau director, and the other top administrators in HCFA are now and will continue to be working together to achieve HCFA goals by developing integrated and effective policies. I think this relationship is long overdue betweeen our two programs, because there is no question we've had a history of competing and even not too thinly veiled adversary relationships between the PSROs and fiscal agents. I think we've got to put away the weapons; and we are expecting them to sit down and to join in a cooperative effort to develop a vigorous and effective medical review system.

I know, in many instances, fiscal agents and PSROs do have very good relationships, but this has to become the rule. This leads me, then, to discuss the expanded future relationships that HCFA has begun to emphasize between the PSROs and the fiscal agents.

The specific review activities that PSROs are beginning to carry out, as required under the law, are physician services review and ancillary services review in the hospital setting. Again, rather than having the PSROs reinvent the wheel, we'd like to see the PSROs and the fiscal agents develop solid working relationships and use one another's expertise. Limited budgets and efficiency awareness simply doesn't allow us to permit duplication.

We feel that the fiscal agents have sound data and analytic skills that should be built upon and utilized to the maximum. PSROs are available to provide their medical expertise to the fiscal agent, to develop or modify screens and adjudicate difficult problem claims.

So, where are we now in physicians' review and in ancillary services review? First, physicians' services. This past June, a draft transmittal instructed PSROs to begin working with carriers to link Part A with Part B. This was the so called Type 1 of three possible types of interaction between PSROs and particular carriers. In other words, this would require the PSROs to go ahead and review their focused cases and, if necessary, deny physician inpatient services and notify the carriers of their denials. Linking Part A and B was felt to be just a logical extension of the review process, since it really makes little sense to deny Part A and not Part B.

Because there obviously will be some operational problems in beginning this interaction, HCFA plans to convene a technical advisory group this spring or summer to include carriers, State agencies and PSROs, to explore possible problems, resolve them, develop operational parameters as guidance.

Now, the second, the Type 2, kind of interaction between PSROs and fiscal agents includes the carrier requesting PSRO medical necessity determinations on the difficult claims that have been identified by the prepayment screens.

The third type of interaction, which is carrier referral of problem physician profiles to the PSROs, we feel is most likely to have the greatest impact on strengthening the medical review system, because PSROs and carriers will then be able to avoid data duplication and to work with each other to identify those physicians whose practice patterns are questionable. PSROs then can go ahead and work with these physicians to help modify their behavior.

In evaluating these three types of interactions, we have set up five demonstrations between carriers and PSROs around the country. For the most part, these demonstrations will be ready to begin making referrals by next month, and should last between 14 and 18 months. Their experience should provide us with valuable guidance as to how to go from here.

At present, we feel we are going to be emphasizing Type 1 and 3 reactions. In other words, the A-B linkage and the referral of problems and profiles to the PSRO. We are concerned that Type 2 interaction, ongoing PSRO involvement in medical necessity determinations, would be burdensome and very costly. I've had personal experience in this region with the kind of problem we got into in Part B review, when it went on-line with tremendous delays in claims processing, and we interfered with the really finely tuned system of claims review.

So, in the meantime, until final policy and guidance is out, PSROs and carriers should begin thinking about and begin developing review methodologies that will work best for their own particular systems.

Now, on to ancillary service review. Although the policy for ancillary service review has been out to the PSROs for some time, budget restraints and technical difficulties have hindered most PSROs from even beginning ancillary services review. This is now changing as we are able to provide to particular PSROs financial incentives and supplements to their budgets. Some PSROs are even reviewing ancillary services without any special funding.

Approximately 70 out of about 180 PSROs are now reviewing ancillaries, all employing various review methodologies. Very few of these PSROs are performing binding review. Most are utilizing the medical care evaluation approach to ancillary services review and, as ancillary service review progresses, we will be encouraging PSROs to work with fiscal intermediaries, especially using data screens to help identify problem ancillaries. And as with physician services review, you and the PSROs can considerably strengthen the impact of the ancillary services review.

We also expect PSROs and fiscal intermediaries to continue to develop other forms of ancillary service review, such as assisting the fiscal intermediaries with ancillary determinations, and having the PSRO focus on ancillaries, and making review determinations for bill denial purposes, in some cases.

A specific area in which PSROs and fiscal intermediaries will be asked to work together is on routine admission studies. The intermediary manual has been revised to require the FI to deny payment for diagnostic procedures not specifically ordered by the physician, those not necessary or duplicative of the same tests that were provided just prior to admission. So, policy will shortly be distributed asking the PSROs and the intermediaries to work together in this regard.

I want to call your attention to an important change that we expect to be made very soon with regard to physician services and ancillary review, and that would be the withdrawal of Section 466.10(c) of the PSRO Hospital Review Regulations, which were issued June 4, 1979. This section relates to the physician ancillary services that are incident to the hospital stay. It

says that a PSRO certification of a patient's admission or continued stay will constitute approval of all health care services provided or proposed to be provided during the certified length of stay, unless the PSRO specifically reviews and disapproves a particular service. And conversely, if a PSRO makes an adverse determination on medical necessity of the stay, all the ancillary services provided during that stay would likewise be disapproved. That section will be withdrawn. There has been a lot of confusion as to who is responsible for ancillary services review and, in some cases, it has actually resulted in no one doing the ancillary services review.

So, an intermediary letter and a general memorandum are going to be issued shortly. They are going to explain that this section of the regs will be withdrawn and that, in the interim, where PSROs are unable or unwilling to fulfill their responsibility for review of inpatient ancillary and/or physician services, fiscal intermediaries and carriers are going to be asked to go back to the existing preregulation policy, unless or until an MOU has been signed with the PSRO authorizing the PSRO to review these services and make the medical necessity determinations.

This will be followed by a Notice of Proposed Rulemaking. It will contain the draft language to this section and will set out in detail the interaction between the State agencies, fiscal agents, and PSROs in regard to ancillary services approval.

Finally, ambulatory care review. PSRO activity in ambulatory review is very limited at the present time. There are only six demonstrations performing ambulatory review. Some of these demonstrations are actually using a claims review process, and although no PSRO movement into this area is expected for quite some time, a claims screening system, working in conjunction with the State agency and the carrier, looks like a very promising alternative for a productive working relationship between the PSROs and fiscal agents.

In conclusion, I would like to say that we expect fiscal agent PSRO cooperation and coordination to bring about a more efficient and a strengthened utilization review system. Health care cost containment will be dependent on the combined strengths and the resources of both you and the PSROs.

MR. WHITE: What I am about to say relates somewhat to the discussion yesterday, especially some things alluded to by Jack Buelt, representing the President's Management Improvement Council; and also relates to what we are talking about today: measuring the quality of performance.

I feel, no matter how sophisticated the measures of performance become with respect to functional standards and statistical measures of cost, quality and service, the HCFA evaluators should be aware of an intangible factor present in each contractor's operation that is virtually impossible to measure. That is, the philosophy and attitude of management.

The true quality of a service function, including customer or client relations, employee morale, innovation and cost awareness, depends more than most people realize, or want to admit, on the attitude of management up and down the line.

Assuming that the work environment is satisfactory, that total compensation is competitive, employee morale and performance will be directly influenced by management. While claims and correspondence may be processed in a timely fashion, does the manner in which these functions are performed leave a bad taste in the mouths of the beneficiaries and providers? Is the ultimate goal only to meet performance standards, or is it to beat the standards through innovative techniques, but always being concerned about beneficiary and provider relations and total program costs?

It is my contention that management attitudes will determine the answers to these questions. Somehow, the evaluators of contractual performance must be aware of this, and somehow -- and I don't know how -- consider this factor in the final analysis of performance.

MR. RINEHIMER: Very quickly, I would like to make one comment on PSRO. We have been selected as one of the demonstration sites. Under this project, the PSRO will refer to us adverse institutional review determinations for possible denial of physician services that were rendered during the hospital stay. Dr. Schneider mentioned, maybe if Part A cuts off, Part B should be cut off. That's not so simple. You may not require the hospitalization, but the services of the physician could still be required outside the hospital. The other part of the two way street is that we will refer individual claims to the PSRO where physicians' services may be considered medically unnecessary. We'll refer to the PSRO patterns of questionable practice, as determined by analysis of our claims data.

What this will lead to possibly, is an involvement of the PSRO in the setting up of parameters and screens for our use in the adjudication process.

Now let's follow this through. We have twelve PSROs in Pennsylvania. If this were to develop this way and their involvement became manifest, would they be asking us to set up all sorts of different parameters and screens in our computer? Then what happens to this matter of consistency?

Now for the ramifications. You have the expense of the communications of the carrier to the PSRO, the PSRO to the carrier. You have the problem of preserving confidentiality, and then you have the decisionmaking which would take a coordinated effort.

Now, this costs money, and when I think of all these things along with compliance standards, and then HCFA says to me, "Now, we are going to put you out on bid" -- I'm going to have to take all of these things into account. I'm wondering how I am going to do it.

But those are the challenges that you and I face. They have to be met somehow, and somehow we'll meet them. In the ambulatory setting there is a way. We have an advisory system of 150 medical doctors, representing 50 specialties. We use them not only for the hospital setting, but for out of

hospital stay as well. It's effective, it works, it's simple. The turnaround time on their decisionmaking is around 14 days. Not bad. I think if you ever get into the ambulatory area, you should take a hard look at something like that, so I offer it to you.

COMMENT: It would be a mistake to let this opportunity pass and not express the very serious concern that a number of intermediaries have with across the board evaluation programs.

First of all, I think it is highly subjective in its application. As John mentioned, you should always be as objective as you can possibly be. Nevertheless, CREP is highly subjective in its application.

There are other problems with it that need resolution. For example, there should be a separate CREP for no audit settlements -- and I understand that there will be, although I haven't seen it raised. There should be a separate CREP for limited audit settlements. I think that more emphasis should be placed on the quality of the desk audit and less on the audit, because the Medicare audit is now a full scope audit.

In summary, I would only ask that you evaluate us on what we do in the audit process, and not on what we don't do.

MR. BERRY: We spent a lot of time working on the no audit CREP, the limited audit CREP process and the quality of the desk audit. Let me say where we are now, although a decision has not been made.

First, without a firmer standard on just what has to go on in the desk audit, it is pretty hard to proceed past that point, and we want to step back and encourage a better definition of what a desk audit should be, what variance analysis ought to be carried out, and what should happen as a result of these specific variance analyses. That leads you into the next step because we're now thinking that a separate kind of a CREP program for no audit or limited audit just doesn't fit; that we want to evaluate the way the cost report was settled. Part of that evaluation would be a critique of the kind of audit that the intermediary applied, whether they did a full scope audit, a limited audit or no audit at all in a particular area.

I'm not sure just yet where that would take us, but in trying to develop a separate CREP program for no audit and limited audit, we just couldn't get any place. Whether that's us or whether that's the nature of the program, I'm not sure yet. I would see, right now, a single CREP program, but one step up in the process, a tighter definition of what a desk audit really should be. So part of our evaluation of an intermediary would be, as a threshold, did the intermediary carry out this tightly defined desk audit and what did they do with the information that was produced. Then you take the next step into an evaluation of the cost report settlement process.

We'll be open with this. We'll share our thinking on it as we go, in whatever the right form is, the TAG or the other meetings, but that's our thinking right now.

PROGRAM INITIATIVES

FOR IMPROVING SERVICES TO BENEFICIARIES

Moderator:

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Panel Participants:

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Mutual Hospital Insurance, Inc., Indiana

Peter D. Mills
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Barney Sellers
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Dorothy Ryan
National Council of Senior Citizens

Patricia Schoeni
Office of Public Affairs, HCFA

MR. HANNA: I'm Lindsay Hanna, director of government programs for the Connecticut General Life Insurance Company. We are the Part B carrier in Connecticut.

I'd like to quickly introduce the members of our panel. This is the order in which your panelists will make their presentations.

Barney Sellers, the director of the Office of Beneficiary Services; Dorothy Ryan, president of the Ohio Council of Senior Citizens; Donald Sloo, vice president of government programs of Indiana Blue Cross and Blue Shield; Peter Mills, vice president and chief Medicare administrator, Occidental Life of California; Pat Schoeni, director of the Office of Public Affairs in HCFA; and Mildred Tyssowski, director of the Bureau of Program Operations.

I know it is dangerous to try and define a complicated area in a few words, but I would just like to set the stage for beneficiary services.

For the purpose of our panel, we should be considering those functions and activities which are over and above the basic role we have of administering Medicare benefits, functions and activities that involve contact with the beneficiary population, written communications, telephone, face to face contact.

The beneficiary is the real client or customer of the Medicare program, although frequently intermediaries and carriers must deal with the beneficiary through the institution or the physician.

Let me suggest that most of our functions -- claims processing, audit and reimbursement, etc. -- are designed to meet the letter of Medicare statute and regulation. I suggest to you that beneficiary services are activities which meet the spirit of the law and the regulations.

MR. SELLERS: I arrived at HCFA in October 1979, and our office was formally established by the Secretary, at Mr. Schaeffer's request, this past December.

We are, in a sense, the new kids on the block, and I am at the very beginning of what I would call a new education process, trying to learn as much as I can about the two very complicated programs.

What I would like to try to do is spend a few moments telling you about the office, what it is doing now, what it intends to do, and share with you some personal observations that I've made as a result of being on the job for a few months.

Let me, first, however, make a general comment about Medicare itself to set the functions of my office in some perspective.

Although Medicare -- and to some degree, Medicaid -- has made a substantial contribution to providing financial access to health services for the aged, the fact remains that since these programs were created, they have had a limited and, in some instances, a decreasing impact economically on the lives of the people they were intended to serve.

Medicare coverage of the total aged health care bill has remained relatively constant since the program was created, but this coverage accounts for less than half of that expense. Beneficiary out of pocket expenses are higher now in current dollars than before these programs were created. Access to services, ease of administration, and client satisfaction have been affected by physicians who accept assignment, and while assignment rates vary dramatically from State to State, nationally, over the years, that rate has declined.

Finally, the net Medicare contribution to physician services, if one takes into account the premiums paid by beneficiaries, is about 30 percent.

On top of this, we all continually find ourselves facing the consequences of widespread public misunderstanding, to some extent our own fault, that Medicare will pay for either all medical expenses, sometimes assumed by those who just enter the program, or a flat 80 percent of all charges, or for certain items which the law simply does not provide for.

In the midst of this comes a new small Office of Beneficiary Services. Let me say, flat out, that this is not a front or a public relations gambit. It will not, blindly and emotionally, represent a consumer point of view without careful thought and analysis and facts. It will take its job quite seriously and approach it quite professionally.

Our general tasks are as follows: to increase communication with beneficiaries, especially at the national level, and help them to influence what we do; to review and reassess our information strategy and beneficiary information products; to use the financing programs as a vehicle for providing practical, effective consumer education; to make our own managers and employees more sensitive to the human side of our programs -- and when I say "our", I mean your employees as well; and, most relavant to you, to review and assess the way in which we administer our programs for beneficiaries, this being clearly the most difficult and sophisticated of the tasks.

So far, we've started the organizational process of the office, which, in the Federal system, is a relatively complex thing to do. We've laid out a long range plan for beneficiary services, containing specific program proposals for both policy initiatives and operations for the next several years, and we have taken some modest first year steps in preparation for a more active followup period in the succeeding couple of years, including: an inventory of what beneficiary services activities we now have underway; a request that the Department's Inspector General conduct a service delivery assessment of all beneficiary services provided by contractors -- that is now underway as well; a national training program for beneficiaries on the pros and cons of purchasing health insurance policies which supplement Medicare, anticipated to start in the middle of this year, and preparation for anticipated administration of new legislation in this area; preparatory steps in our regional offices to assign responsibilities for this area in anticipation of substantial and more specific responsibility later on; a survey of the way in which HCFA's research and demonstration budget is spent in regard to beneficiaries, and initial meetings between the Administrator and the beneficiary groups.

In short, the first few months have been spent modestly in an effort to get our own house in order and to prepare for what I anticipate will be much more active and productive months to come. During this period, however, I have traveled both within HCFA and around the country in an effort to understand some of what we do now. I've had the pleasure of visiting some of you and appreciate your diligence, professionalism and dedication, and the complexity of your work.

Permit me to share some random observations on what I've experienced and seen thus far.

Beneficiary services is seen, in general, as a special, white hat, ancillary activity, not integral to our basic mission. Our ability to assess both impact of our programs on the health status of the population we serve, and the quality of the mechanisms we use to carry out the job appears very limited.

Program evaluation is virtually nonexistent, and self assessment is sometimes superficial. The beneficiaries' confusion about the financing system in general and our programs in particular is extraordinarily high, and there is probably no total answer to this because of its complexity.

In some instances, we appear to succeed in educating and explaining complex questions and in other instances we appear to fail. The quality of current SSA district office Medicare services varies considerably and, in some instances, is simply unknown.

Proposed changes for contractor, HCFA, and SSA service relationships have the potential for reducing services to beneficiaries, as well as improving them, and the current nature of that relationship is, in my opinion, very unclear.

The message that we, HCFA, have given you, the contractor, regarding holding down costs, while at the same time upholding high standards for quality service in an increasingly competitive atmosphere, has been both conflicting and vague. We have not yet put our money where our mouth is when it comes to beneficiary service.

Quality control has been defined almost totally with regard to cost containment. In my judgment, in the private sector, such an approach would be unacceptable.

In general, although there are striking exceptions, beneficiaries don't understand the forms you send them and the letters you write -- and, neither, frankly, do I.

Telephone services I have observed, while in general still in an infant stage, have both positive and negative characteristics. Many telephone answerers handled complex calls, that I listened to, competently and pleasantly, but their services were depreciated by consumer difficulties in getting through in the first place, and excessive use of jargon.

We do not have, as far as I can tell, an adequate system, right now, to currently measure the quality of that service.

Almost everything we write and say is filled with jargon, which is simply not understandable and is used primarily for our own convenience.

We have an appeals system which is structurally suspect and a reconsideration system which is not uniformly administered and appears often too imposing or untrustworthy to the beneficiary, rightly or wrongly. Most beneficiaries who have doubts about the adequacy of claims paid assume that you keep the money that is not paid out.

There are points in the claims payment system requiring judgment; for example, the application of screens. And there is some concern about the quality of service and the judgment that is used at these points. My personal impression is that frequently both the complexity of these programs and the manner in which they are administered does not leave you with a public relations plus for potential private business.

Contractors have not assumed the public service role, or do so reluctantly. That is, there appears to be a great resistance to provide service on those variety of inquiries that are not directly related to the payment of claims that you handle. We have failed, to date, as Federal administrators, to clarify and rationalize an effective national system of beneficiary service, which incorporates a field office component, a contractor component, and a national office component.

There do not seem to be major problems on turnaround time for claims processing and, in some cases, this handling, to me, was very impressive.

Special beneficiary projects, administered at the site of service -- that is at the site of health service -- with common sense as well as sensitivity, appear to serve hospitals and carriers, as well as elderly people, reducing costs as well as confusion.

Finally, the multi-layered complexity of our system removes most of the actors from the people who are supposed to be served. In a highly competitive private sector business, this would probably lead to considerable consumer dissatisfaction and loss of market penetration. You and we are saved from some of that consequence, if not all of it, because we have a monopoly.

What can and should we do? I can only share with you some initial thoughts.

We should develop a better Federal capacity to measure program impact on health status and on access to services; expand our definition of quality control to include oversight of denied services as well as true quality; improve our own capacity to judge the effect of our actions on beneficiaries and be prepared to pay a price for doing so.

The conflict between cost saving and quality service must be surfaced and resolved wherever it is necessary to do so. Correspondence must be improved. The EOMB must be redesigned. Money for special beneficiary service must be set aside, and more careful studies of the quality of the basic claims decisions made.

We must have a quality field presence in one form or another. People must have other people available to them, face to face, to deal with as long as they are part of the reimbursement system.

The impact of proposed policy and operational changes on beneficiaries must be made explicit and public before they are made.

We must move away from standards which are process oriented and aimed at internal mechanics and administrative forms and toward outcome and quality standards as well.

We should have a way of rewarding quality service by the contractors, as well as low cost operations.

Our information materials must be made part of the larger public information strategy which takes into account the age, education, health status and interest of the people we are seeking to reach.

Some of these thoughts are neither new nor earthshaking. Some may require major change. Which should be proposed or accepted now? I simply don't know. But it appears to me that, over time, we will all pay an increasingly heavy price if we fail to face and resolve some questions which have plagued the program for years.

I hope, with the creation of our new office, and working closely with the other bureaus of HCFA, that we will demonstrate a new institutional capacity to do that and, with your cooperation, we'll succeed.

Some of the standards we must use to judge the accuracy of our efforts are sometimes more diffuse and more difficult to define if the suggestions I make are followed through on. But that should not mean a lack of commitment to reach them.

Our job is to make big government into small government for our elderly; a government which is human and humane, which listens, reaches out and responds. When we do that, we will be doing our jobs well.

The people we serve have a right to expect nothing less from us and we have an obligation to keep trying until we succeed. We must build a system which incorporates those kinds of qualitative considerations into the standards we use to judge performance by ourselves as well as by you.

And it is not an easy task.

MR. HANNA: I want to take a couple of moments to describe Dorothy Ryan for you, because it is a real pleasure to have Dorothy here. She is the president of the Ohio Council of Senior Citizens. She serves on the Board of Directors of the National Council of Senior Citizens. I've spent a number of pleasant moments with Dorothy, here, and know that she is working literally full time in the best interests, as an unpaid volunteer, for our senior citizens.

We have with us truly the voice of the client.

DOROTHY RYAN: As a Board member of the National Council of Senior Citizens, I would like to present some of their concerns about our Medicare beneficiaries receiving the necessary information and assistance to enable them to fully utilize the Medicare program.

This is very important to the National Council of Senior Citizens because they feel a responsibility to their well over three million members in the 3,884 clubs affiliated with the National Council throughout the nation.

As President of the Ohio State Council of Senior Citizens and its 120 affiliated groups representing some 300,000 senior citizens, and as President of the Northeastern Ohio Senior Citizens Council, representing about 20,000 senior citizens in a four county area, I, too, am interested in how problems can be corrected or eliminated so I may be of assistance to the members of these two organizations.

We realize that Medicare was not a full answer to the health care crisis of the elderly when it was enacted in the 1960's. But it has been a successful partial answer -- if we can make it possible for Medicare beneficiaries to make full use of the benefits available to them.

Medicare has exposed the flaws in our present health care delivery systems, the ineffective cost controls, uneven quality of care, and the neglect of the patient using Medicare.

Realizing all of these factors, we must make every effort to enable our Medicare beneficiaries to implement this program by making them aware of what it does, and what it does not do for them.

I have found that the persons calling me for assistance with their Medicare problems are not very knowledgeable about the Medicare regulations. They have probably received a Medicare booklet at the time they became eligible for the program, and more than likely, never really read it. At that time, they were not particularly interested in their rights and privileges because they had not yet experienced a health care problem.

Some have occasionally heard, or possibly seen, programs covering Medicare regulations, but these programs are usually unscheduled and very brief so no real impression has been made on the individual.

When they become a patient, or their family becomes involved with a health care problem, they become uneasy, confused and in some cases even fearful of consulting a physician because of the possibility that this health care problem is going to result in extremely high health care costs.

I receive many questions concerning the 80% of "the reasonable cost" used as a basis for payment of their claims. They cannot understand why, when their doctor has charged them a certain amount, the Medicare reimbursement does not cover 80% of his/her actual charge. They have asked who sets the "reasonable charge" and what arbitrary guidelines are used in deciding which charge is "reasonable" in a given area. Frankly, I, too, would like to explore this further.

One of our people asked his doctor why his fee increased every time a new "reasonable charge" was set for our area. The physician replied that they do this so they will already be eligible for a higher scale the next time the "reasonable charge" is reviewed.

From personal experience, I can sympathize with the person losing their spouse and trying to cope with resulting Medicare problems. They now discover that the death of their mate results in a different approach in securing Medicare reimbursements. They find they have two choices -- and not really two choices since one is almost impossible to secure. They must either pay the deceased's bills in full and then return the paid receipts and necessary forms to the carrier, or they can try to have their doctor accept assignment. We rarely find a physician willing to do this as they do not wish to accept anything less than the full charge they have made for their services.

Even though I felt I was reasonably knowledgeable about Medicare procedures, I had not been aware of this particular regulation until I was forced to face it at the death of my late husband.

One of our Regional Council members told us that his deceased wife's medical bills were so extensive that he had to borrow money to comply with this regulation before he could get the Medicare reimbursement. Something needs to be done to change this regulation of the program.

I really became aware of the lack of available information concerning the Medicare program about two or three weeks ago. I had been requested to speak at the Youngstown State University. The class involved had expressed an interest in knowing something about the Medicare program. I felt that if I took some Medicare booklets with me, these students could later use the booklet for referral when they found they could not remember something I might have presented to them in class.

I was surprised to discover that there was some question as to whether the twenty-five booklets I needed would be available at the local Social Security offices. Although they were able to find the necessary books for me, they could offer no assurance that they could later furnish the 75 copies I requested for the March meeting of our Regional Council. When I suggested that I would write the national Social Security Administration offices, I was advised I would have a better opportunity of getting the necessary copies if I waited until they contacted the area offices in our regional district, to see if they could pick up the 75 I needed.

They also explained that the short supply exists because many insurance companies request quantities of these handbooks for distribution to their clients and customers. This practice should be discontinued if it means our beneficiaries are not going to find copies available when they need them.

Although the booklets I did get were a recent issue, they still were not up to date as far as the deductibles were concerned. This means that any recipient of one of the booklets is going to become angry and confused when he/she makes a claim and finds he/she has not yet met the present deductible.

Perhaps it might be well to mail directly to each beneficiary, a copy of the latest Medicare handbook. When changes are made, a special leaflet should also be sent to the individual Medicare beneficiary. These could be placed in their own handbook for reference. Some of our larger minority groups would benefit by having a handbook printed in their own language which would make it more easy for them to understand the regulations.

The National Council of Senior Citizens has embarked upon a program rendering assistance to Medicare beneficiaries to take care of the problems they may have under the Medicare program. They have done this in cooperation with the Medicare Bureau. It started with inpatients at the hospitals who, because they were ill, may be in greater need of such assistance than any other group of beneficiaries. Special Medicare beneficiary aides were instructed in skills, knowledge and capabilities enabling them to carry out this assistance.

However, it was discovered that the problem was not really too great for patients already in the hospital. Most hospitals have a Medicare department with personnel fully cognizant of all the regulations and the patient usually has very little to do except sign the Medicare form. Some hospitals have social service departments which perform this service and they resented having the Medicare beneficiary aide approach the patient in the hospital.

The very real need was found to be assistance for the persons trying to cope with Part B of the Medicare program.

Many of them do not know who the insurance carrier is, and many of these carriers do not have an office in the community. They discover their doctor does not accept assignment, so they are left to handle the Medicare form themselves.

Some physicians charge from $1.00 to $5.00 to complete insurance forms including the Medicare form. If a claim is denied because the doctor has not provided sufficient information to explain his charges, the physician resents having to fill out another form.

We have found our people paying their doctors before they ask them to complete the Medicare form. In many instances it then takes longer to receive the completed form from the doctor's office. They have already received their money and are in no particular hurry to get the form completed. I would have to agree, though, that this might usually be the fault of the office manager or secretary who is negligent in completing the form and getting the doctor to sign it so it can be mailed to the patient or the Medicare carrier's office.

Many beneficiaries are confused and exasperated when they have a Medicare form returned for additional information. If they have other insurance coverage, they are inclined to accept what they have received from Medicare and hope that their other insurance will cover any additional difference.

Few, if any, are aware of the procedure to follow in requesting a review or special hearing of their claim, even though they feel they are entitled to more reimbursement. They are not aware that their Social Security office could do this for them.

Because it is a government form which many do not understand, some less informed individuals and many with minimal education, fear signing the Medicare form. Some of our elderly fear any government forms because they are afraid they will lose their home by signing them.

Our Medicare carriers are often more concerned with cost savings to them rather than with beneficiary services. They report that it takes longer to serve the Medicare beneficiary than it does to take care of their private clients.

Although at one time the people in our area had a problem with the carrier taking much too long to handle their claims, this has generally been corrected.

Many of our Medicare beneficiaries are unable to get to the local office of the Social Security Administration to receive assistance with their Medicare problems. Handling it by telephone calls is usually not satisfactory. They cannot get to the Social Security office because of some personal handicap, advanced age of the beneficiary, or lack of mass transit transportation in their community. Many do not own cars, and many cannot drive the ones they might have had. It is particularly difficult for those living in rural areas. Many areas may have a toll free number to be used in seeking Medicare information, but it is forgotten by the time the individual needs this help.

Some information has been made available through TV programs or commercials, newspapers and other public facilities, but it does not seem to meet the need. Some of our older people cannot read too well, some do not even buy the daily newspapers, many are not interested in TV, and some do not own TV sets. Some have hearing or visual handicaps which also prevent them from getting this type of information.

I recently made a survey of the senior citizens attending the various meetings at which I appeared. I asked how many understood the Medicare program, knew how to fill out Medicare forms, or how to appeal cases that were rejected. Only one or two individuals had any real knowledge of the problems involved in submitting Medicare bills. Those who did, indicated they had acquired their knowledge through a "hit or miss" "trial and error" process when they were faced with the necessity of filing Medicare forms for reimbursement. Their first question was, "Why could we not have special meetings or programs to introduce us to the procedures necessary in filing Medicare claims?"

We would like to see some local educational programs such as workshops or seminars, where our people could learn exactly what the Medicare program is all about in language they would understand. They could fill out sample Medicare forms to learn how it is properly done, act out a hearing for a claim they felt had not been properly handled and ask the questions that bother them the most.

It would also be an excellent idea to develop an outreach program so we could make sure every Medicare beneficiary who needed assistance was given this help.

Since many communities have nutrition sites, this outreach worker could service many individuals at one time if their visits were made at regular times. The same service could be given by an outreach worker who made routine visits to senior centers and a worker who might make routine visits at scheduled times to senior citizen housing units.

Individuals who might be unable to attend meetings, and could not leave their homes because of health problems, handicaps and transportation problems, could be serviced by the outreach workers making individual house calls to assist such Medicare beneficiaries.

Our Medicare beneficiaries want to be reimbursed for their health care expenses. There is little doubt that most of them do not understand the basis for denial of benefits, or why they receive reimbursement of their doctor bills at 80% of a "reasonable cost." I have had many who were indignant when the Medicare reimbursement did not cover a full 100% of their Medicare claims. When they appeal a case and end up with no more money than they originally received, they are angry, frustrated and disgusted with the program. Their attitude becomes, "I should have known you can't fight the government."

We know the problem exists. We know our Medicare beneficiaries are not getting the full benefit of the program. We know most of them do not really understand the regulations. This problem must be met with an early solution before the program becomes useless to many of our beneficiaries.

It would seem logical to make it posible for them to receive the benefit of an educational program enabling them to deal realistically with the benefits of the Medicare program before submitting their claims, rather than wait until they become angry and frustrated when reimbursements do not meet their expectation.

This could result in less cost involved in returning claims for investigation, fewer requests for hearings in review of claims, and reimbursements could be made more quickly and efficiently because the Medicare beneficiary understood how to properly fill out the required forms and submit bills.

MR. SLOO: I think the real trick today is not to get them, but to keep them, as far as Medicare A and B and Medicaid is concerned.

One of the first things I did in preparation for today's meeting was to go to the contract, which is the guiding document as far as contractors are concerned, so that I could define for you beneficiary services.

Now, that's a very difficult thing for me to find in that contract. There is only one reference in that 30 page document to the subject of beneficiary services. This is under "Functions of the Intermediary," in Article 2, Paragraph N, a small one liner, "upon inquiry, assist individuals with respect to matters pertaining to this agreement."

Now, from this very brief, passing reference, there is a whole multitude of activities that spring forth, and all of these resources that are expended to support this function create an administrative expense of some magnitude for the contractor.

This obligation is one of the most difficult for the conscientous contractor to perform. A byproduct of any business endeavor is the development of satisfied customers. This is a very difficult thing to accomplish, particularly in those cases, when, following program guidelines, the contractor is not allowed to make payment in full or has to deny payment for a particular service.

In the performance of this function, we are not dealing with pieces of paper, statistical data, preparation of reports, but we are dealing with living, breathing human beings who are often confused, anxious, irate and, many times, stretched to the limit of their endurance with something they don't understand.

You're beginning to hear the same theme that has been permeated through the previous speakers and is also very obvious in my remarks. The crux of the matter is Medicare beneficiaries simply do not understand the program. The program is often maligned unjustly by Medicare beneficiaries as well as self-styled critics, basically because they don't understand the complexity of the program.

In operations, we can do an awful lot to automate and make ourselves more efficient. We can try to secure source data entry for claims input. We can do a lot of things. But in the one on one function of beneficiary services, it is very difficult to automate that process. We can give our people some automated tools such as on-line devices to speed up their research and make it more efficient and more effective. But the real secret is how you perform better one on one relationships.

Well, I think I would like to talk about some of those things a little bit later when I talk about how I think beneficiary services can be improved.

Back to the misunderstanding theme. Medicare beneficiaries don't understand the application of terms such as deductibles, coinsurance, exclusions, reasonable and necessary, usual and customary, lifetime reserve days, economic index limitation, assignment, on and on and on. And you've heard this referred to as a jargon -- and it is a jargon. It is the language and the tools of our trade.

The basic truth is the Medicare program is a very complicated program to explain. The original legislation was complicated enough, but with 15 years of legislative changes, administrative decrees, well intended sophistication, we have created almost an administrative nightmare and a confusing program for the Medicare beneficiaries it was intended to serve.

A little bit about Indiana Blue Cross and Blue Shield. We would probably be classed as an upper middle class contractor in terms of claims volume. I will relate my remarks basically to the intermediary side, as Peter is going to speak to the carrier aspects of beneficiary services.

On the intermediary side, we have a ratio of about one percent inquiries to the number of claims processed. Now, you think that's a very good ratio. Well, it is, because on the Part A side, which is primarily a vendor oriented program, there is not nearly as much confusion and as many opportunities for beneficiary interface as there is on the B side.

I think if I can address those problems that we are encountering today, it may lead to some recommendations for solutions of some of these things that we can do down the road in the future.

The Number 1 problem I have alluded to earlier is the lack of education. Many inquiries we receive are of a general nature. Sometimes new beneficiaries, just eligible for the program, who have not even filed a claim, want general information about the program. I would quickly point out to you that Medicare contractors do not have a contractual function to educate beneficiaries of the program, but, as a result of the transactions that we enter into, we are forced to play this role. If we are to have customer satisfaction, then we must interject ourselves into the role of educator.

Another problem is the Medicare beneficiaries do not understand the provisions relating to skilled nursing care; the difference between custodial care and covered care precipitates many Part A inquiries. Given the fiscal considerations, I'm not sure that we can do anything at the program level to alleviate this problem. But, once again, I think it has to be attacked through education.

A Privacy Act backlash is another thing that is creating problems for us in providing the services to beneficiaries. Many Medicare spouses simply cannot understand why they cannot secure information, and this is due to the Privacy Act which was primarily developed in the interests of the beneficiaries, but it has a backlash effect in not being able to allow them easy and ready access to information without the required informational releases.

Another problem we've encountered is the lapse of time involved in the preparation of record of benefits used. This is done in Baltimore and it is usually several months after the Medicare beneficiary has received hospital services. They simply don't understand why four or five months later they would get this notice, and many of them have completely forgotten about the service that was rendered.

Now, those are some of the problems. What can we do to try to correct those problems and improve the beneficiary services?

Contractors can, I believe, do many things, but first they have to be motivated to do those things. Because of constant pressure on administrative cost considerations, contractors are reluctant to spend monies unless the cost benefit is attendant.

The following are some examples of things that I think we can do to expand our services and still meet administrative cost standards and appear favorable in certain cost comparisons that everyone is interested in now.

I think we can establish closer liaison with local senior citizen groups, primarily to conduct instructional classes pertaining to the program. The intermediary will not gain as much in administrative cost reductions from this activity as the carrier will because of the vendor initiated claim aspects of the Part A program. But, still, if we can conduct an educational program, we may cut down significantly on those inquiries that we might receive later on.

The Intermediary can establish an ongoing set of initial meetings with new beneficiaries by working with the local Social Security office. Faster updating of the Medicare handbook, which has been referenced earlier, would be a valuable assist to the contractors in these types of activities.

Another thing is that we can simplify the reconsideration process. On those cases that require medical review, a very lengthy document is sent to the beneficiary to explain to him/her how the initial decision was made and how the review decision was made. For the most part, the Medicare beneficiaries do not understand this very lengthy document.

I think we could develop, if given the opportunity, a very simple, short, plain language response to these requests for appeals, particularly on institutional services.

I alluded earlier to the lapse of time in preparation of record of benefits used reports. These could be, in my opinion, prepared at the local intermediary level, which would cut down significantly on the time lag.

One last observation. In the future, if Medicare contracts are to be awarded on a competitive bid basis -- and that seems to be what is going to happen -- I don't believe that some functions should be part of that bid process. If prospective contractors who submitted a fixed price bid on the production related contractor duties could also include in that bid their willingness and qualifications to perform beneficiary services and other adjunct support activities, then these services could be agreed to outside the base contract.

After the selection of the winner, the winning contractor would then submit a work plan as to how he would perform these beneficiary services. The work plan would be a detailed listing of activities that he proposes to provide under the function of beneficiary services, with a cost projection for each of these activities. This would allow HCFA to negotiate with that contractor for the level of beneficiary services that they actually want provided.

In closing, it seems apparent that those contractors who will promote a better understanding of the program will be those contractors who can provide better service to the beneficiary. When that occurs, the Medicare program can be elevated to the stature that it justly deserves in the eyes of the population that it was designed to serve.

MR. HANNA: In introducing Peter Mills, who will speak to us on beneficiary services from the point of view of the Part B carriers, you should know that Occidental in Southern California is one of the giants in the Part B program; they have a huge operation, and I know they are doing a lot in this area.

MR. MILLS: I would like to draw your attention to this display board and, as you can see in our centerfold, we have a typical Southern California couple, sitting in the sunshine, and because of our recent heavy rains, you can see in the background their house sliding gently down the hill in a sea of mud.

Well, I'm afraid we can't do much at Occidental to help them about their house, but at least we can help them with Medicare. This is why at Occidental we say, we put the "I care" in Medicare.

In serving over a million beneficiaries in Southern California, we maintain a mix of beneficiary activities and we continue to add these as we add other projects.

I feel these activities fall into two basic categories. First, there are those items that are required by the Health Care Financing Administration, and Don Sloo referred to many of these, such as, correspondence, telephones, and of course, walk-ins.

We are very fortunate with the walk-ins at our Medicare office. The Occidental Center happens to be one of the Los Angeles downtown bus stops. Those of you who are familiar with this know what I mean, when you are next to a bus stop. Los Angeles has a 15 cent mini-bus service from anywhere in town, so we have a great population descending upon us.

These three areas; correspondence, telephone and walk-ins, can be categorized, qualified, and counted. They can be measured and evaluated. The sophistication the carrier uses in handling these services really depends on the type of system that the carrier has and this ranges from a simple one on one relationship, to a total on-line control system.

The second part, which I believe is perhaps the most important, are the items that we do because there is a <u>need</u> to do them. These activities, themselves, fall into two categories: those that take time and cost money, and other activities that I refer to as "freebies." These are the little things that you and I and we can do, as carriers, that will help the beneficiaries and, at the same time, do not cost a great deal of money, but do have a tremendous payback.

Let's take a look at some of the things that we've been doing in Occidental.

Several years ago, we started what we call a speakers' bureau, and we asked our employees if they would like to go out and speak to some of our senior citizens' groups. We'd been working with the various senior citizens associations, and had been sending speakers out, but thought we would augment this by asking our employees to participate. We had over fifty people say, "Yes, I'd like to go out and speak."

We worked with our employees and gave them training and help; so they now have spoken to thousands of beneficiaries ranging from groups of three or four people to groups of 200 or more.

One of the key elements of this program has been that the speakers we use are not professionals; they are basically ordinary people who work in the office on a day to day basis, but they can relate to the beneficiaries very effectively.

Perhaps one of the most important benefits we've got from this program is not just the speaking, but the listening. Our employees come back and say, "Hey, you know there are real people out there. They are not claim forms, not bits of paper. They are actually real people out there with real problems. Many are very ill, and some are in pretty good health; but there are still a lot of people who need help."

And this really puts a little bit of heart into your operation.

We also have established a beneficiary outreach program where we enlist the help of senior citizens to work with their peers. Some people refer to them as beneficiary aides or volunteers; however, whatever you call them, this has proved to be an extremely effective method of communicating with the beneficiaries. These volunteers are available once or twice a week at a local community center where we provide them with some basic Medicare training. One of the things we do not do is try and teach them everything about Medicare. The general function is to help senior citizens complete claim forms, understand the EOMB and give them information on how to request a review. The volunteers do not try to answer complex claims problems. What we have done is to establish a telephone "hotline" so that the volunteer may call a qualified, trained individual who can give them the information over the telephone as it pertains to the particular beneficiary's concern.

The outreach program is highly effective, and we feel that this "low key" approach is getting good results.

Coming from the western sunbelt, we obviously have a great number of retirement communities, and we've worked with the Leisure World in California. They have their own closed circuit TV to all the houses (over 20,000 people). We have had an opportunity to be on a panel answering questions about Medicare; the residents could phone directly in to the panel and ask their questions right there on TV. This was a very exciting and informative program.

Many of the carriers have used EOMB enclosures. This is an item that does not cost anything to mail, and the printing costs are certainly worthwhile to provide information to the beneficiary on filing claims.

While we are talking about enclosures, there are also a multitude of enclosures already available from SSA/HCFA. I think of them as "freebies", because they are generally no cost to the carrier.

Another item that we have put up on the display board is the "old shoebox" claim. This happens to us every year; beneficiaries save up their claims and then at the end of the year, mail big fat packages. We send letters to beneficiaries to suggest that it might be helpful to them to send in claims more frequently rather than hold till year end, as it also benefits them to receive payments as the expense is incurred, and at the same time makes it easier for us to complete the claims.

Another "freebie" is the health fairs. Probably because we have so much fair weather in California (on the contrary to what the news media says), we have a lot of health fairs. These fairs are often conducted by senior citizens' groups, State health associations, and various other civic organizations. Whenever we can, we try to participate by setting up a booth and providing blown up RFP that has a plastic cover on it. We can show people very effectively how to complete the RFP. In one particular gratifying occurence at a health fair, we met a gentleman who had been on the program for eleven years and had never filed a claim, despite many medical bills; we were able to help.

An extension of this is what we call Medicare on Wheels. This is going out of the cities and into the rural communities. Again, here we can work with the senior groups and also with the Social Security Administration offices.

Though the Medicare activities in the Social Security offices may be diminishing, they do have an excellent knowledge of their local area. They are extremely helpful to direct you to who can help you set up the meeting. Medicare on Wheels is really just a jazzy name for getting out into rural areas and helping the beneficiaries. The SSA offices and the local senior citizen groups are very helpful in working with you to put ads on TV. We have always found that the local radio stations are pleased to cooperate. In many of the small areas you will find attendance to Medicare meetings in the 200 to 300 range.

I would like to move on now to a new area we refer to as "at a time of need." When a beneficiary dies, there is a tremendous problem for the next of kin to understand and complete the requirements for handling the claims.

As a carrier, we are not in a position, at this point in time, to change the law regarding unpaid bills, but we can change the way in which we handle the claim. We do have a problem in this area. We've been getting many of these claims in and there is a lot of correspondence back and forth, a lot of misunderstanding; so we thought, why not have the claims come in right the first time? Why don't we contact the next of kin prior to the time they submit a claim?

And where do you do that? At the mortuary, at the funeral home.

We've set up a pilot project with the local funeral association, and they will, in turn, give the next of kin a self mailer that will come to us. We

then send out a brochure containing all the forms, all the requirements, a phone number the next of kin can call, and hopefully, the claims will come in properly completed.

We're also working with the Social Security Administration, the local office in that area, because they are very anxious to help. They work with the next of kin because there are social security benefits which are generally available.

I'm looking forward to some really great things with that program. I think it has the potential to be regional in scope, and perhaps national. I am going to be interested in following it down the road to measure the results.

The whole key to beneficiary service is communication; the way in which you relate to the beneficiaries. It is not just one massive program, but all the little things that we do that fit together.

We're looking forward at Occidental to starting a program where we will receive the claims from beneficaries, notifying us that they have some complementary coverage or Medigap coverage; we will be able to send a magnetic tape record on to their private insurer. Some of the carriers are now doing this and I know our panel moderator's company has done some fine work in this area.

Let's take a look at our display board again. Where are we going to be in Medicare a year from now, six months from now? I can see our senior citizens sitting there in the lovely California sun -- well, wait a minute, I'm sorry, they are probably not sitting this time. Let's see, last year it was the fires; this year, it was the rain; next year we'll probably have an earthquake and it will demolish the bench; so they'll have to stand.

However, if we've done our job as a Medicare carrier, if we've communicated well, if we've paid our Medicare claims promptly and graciously, then perhaps they'll continue to say, "Thank goodness we've still got Medicare."

MS. SCHOENI: The Department of Health, Education and Welfare launched, in September of 1978, a program to encourage all Americans to seek a second opinion before undergoing nonemergency surgery.

The purpose of that program is to expand the knowledge a patient has about his or her own health, to improve the overall quality of care, and to deal with the problems of unnecessary surgery.

The definition of "unnecessary" as it applies to surgery, and the question of exactly how much such surgery is being performed, are matters of considerable debate. Estimates of how much unnecessary surgery is performed range from one percent to 30 percent, with the figure higher for specific surgical procedures.

The variations in rates of surgery among different geographical locations and in different health systems have been identified in a number of studies over recent years. The overall rate of surgery, for example, is 31 percent higher in the Midwest than in the South.

In Federal employee benefit programs, twice as many operations are performed on the fee for service patients as on those enrolled in HMOs.

We know that between 1970 and 1978, the number of surgical procedures increased 33 percent in the United States, and that the rate of surgery is growing four times faster than the population.

Between 1966 and 1976, there was a 44 percent increase in the rate of surgery for people over 65.

The Moss Subcommittee, two years ago, used a 17 percent figure as the rate of unnecessary surgery in Medicaid, and concluded that there were approximately 2.38 million surgeries that were unnecessarily performed under Medicaid at a cost of over $3 million.

The program that we have launched has four elements: first, is the public information activities to acquaint the public with the advisability of seeking a second opinion; a nationwide referral mechanism to provide access to local referral sources to obtain second opinions; two demonstration projects to learn more about a number of issues related to surgical care and second opinion programs; and an evaluation project to assess the impact of second opinion programs on the rate of surgery and on the costs to the Medicare and Medicaid program.

Because there is no single organization capable of serving as a national referral source, HEW worked with a number of local and voluntary programs to make second opinions more available to those patients who desire them. The program, as conducted by HEW, is not limited to Medicare/Medicaid beneficiaries, but is aimed at all patients faced with the possibility of having surgery.

We've established a national hotline to direct patients to local referral centers. The Social Security Administration district offices and local welfare offices also direct consumers to local referral centers.

Local groups have developed lists of physicians willing to give second opinions and provide callers with several appropriate local physicians. The patient has the final responsibility, of course, to follow through on the referral and to get the second opinion.

While we don't know how many physicians are participating or have agreed to participate in the second opinion program, we know that there are over a hundred thousand physicians that have indicated their willingness to do so.

Many groups have taken an active role in implementing the second opinion program, either by being the referral source or by helping with other aspects of the program. Twenty-seven PSROs, 68 medical societies, and 43 carriers serve as the referral centers for a total of 151 throughout the country.

The public information material that we have developed is built around the concept that the individual has a role in his or her own health and has a responsibility for his or her health care. In all the materials, we first encourage the patient to ask their own doctor to recommend another physician for a second opinion, or call our HEW hotline. The toll free number is available 24 hours a day, seven days a week, and will refer the caller to the local referral center.

We have printed and distributed five million copies of our second opinion brochure since January 1, 1980, when we went into our second phase of the second opinion program. We are now in the process of printing two million additional copies of the publication. We have a Spanish version of that brochure. In the first three weeks after we launched this second phase of the campaign in January 1980, we received individual requests for 1.5 million brochures.

We have received a number of requests from insurance companies for quantities of the brochures to send to all their policyholders. We have also developed a poster with the slogan, "Thinking of having surgery? Think about getting a second opinion," and indicating the hotline number. We are now in the process of translating the poster into Spanish, and it will be used in Puerto Rico and other parts of the country.

We have developed a series of TV and radio spot announcements, using actor Cliff Robertson. These spots are receiving good airing at the present time. CBS used them last weekend on network in prime time on both Saturday and Sunday. Those radio and TV spots have been distributed to 700 television stations and 6,000 radio stations throughout the country. Most of the spots carry the hotline number; some carry the tag, "Write Surgery, Washington, D.C., 20201, for additional information."

In addition to the national program, we are conducting two demonstration projects, one in Detroit and one in New York City. These demonstrations are being conducted under contract to Blue Cross and Blue Shield in each of those areas. These two demonstration projects are aimed at the Medicare population, which involves about two million beneficiaries in the Detroit and New York areas.

In these two demonstrations, all copayments are being waived, so the second opinion will be free to Medicare beneficiaries. The physician referral centers actually assist the patient in finding another physician. In addition to giving the names of the physician, in the demonstrations, the referral center actually follows through and helps -- either makes or helps make the appointment with the physician and follows up to see that the patient gets there, even providing transportation, if necessary.

Thus, in the demonstrations, we are going further than we go in the national program.

In addition, in the two demonstrations, there is an intensive consumer education program. In the New York demonstration, they are using mass media, including New York Times ads and TV spots, to get people into the program. In Detroit, they are using community groups to achieve that end.

The demonstration projects are aimed at providing data in sufficient detail to evaluate the impact of second opinion programs on surgery rates, the costs and the quality of care; to determine whether a waiver of coinsurance and deductible liability associated with a second opinion results in increased utilization of the benefit; and to assess how the structured program approach of the demonstration contributes to the cost and manageability of the second opinion effort, as compared with the general awareness kind of campaign that we are doing on a nationwide basis.

The HEW evaluation project is a major effort to learn more about a number of unresolved issues relating to surgery. The evaluation project will focus in particular on the effect of second opinions for nonemergency surgery on the rate and cost of surgery.

We have awarded a contract to evaluate the two demonstration programs, the Medicaid second opinion program in Massachusetts, which is a mandatory program, and our general awareness, nationwide program. The total evaluation is expected to run for four and a half years.

As I mentioned, in that evaluation we are evaluating the Massachusetts mandatory program. The program has been going since 1977 in some parts of the State, later in other parts of the State. Results from the first 14 months of that project, in which second opinions are mandatory for eight procedures, indicate there has been a 20 percent reduction in the rate of surgery among the Medicaid population in Massachusetts as a result. Thus, they are projecting considerable savings from the second opinion program.

We developed our second opinion program after discussions with the medical, hospital and insurance groups and, where possible, we have incorporated their views and their concerns into our final program and into our final publicity for that program.

The American Society of Internal Medicine passed a resolution some time ago encouraging second opinions. The American Medical Association traditionally has supported the concept of second opinions, although they opposed a recent amendment that would have permitted demonstrations of mandatory second opinion programs by the Health Care Financing Administration.

The American College of Surgeons has been opposed to the second opinion program from the beginning and remains so.

Several third party payors' plans, including many of the Blue Cross Blue Shield and private plans, also are encouraging second opinions actively, in addition to paying for them.

The next step in our second opinion effort is that we are going into certain cities in the United States in which the PSROs have identified that the rates of certain surgical procedures are higher than the national average. We will target spots to see if we can have any impact on those surgical procedures in that area.

The first two procedures that we will target are cataracts and prostate surgery. We are going to Houston and into a small town in West Virginia with the prostate spots, and we are going into Tampa and Philadelphia with the cataract spots.

MS. TYSSOWSKI: My personal view is that the most worthwhile thing we could do to improve beneficiary services is to amend the law; i.e., to require physicians to accept assignment if they wish to participate in the Medicare program.

As you know, this is an old legislative proposal that keeps being bandied about. And there has always been a concern as to whether this might be a disservice to beneficiaries in the sense that you wouldn't get enough physician participation. Personally, I don't think so. Also, I wanted to mention that this legislative proposal is somewhat linked, in HEW legislative planning, with the Statewide fee schedule idea. HEW is planning to have discussions throughout the country on the fee schedules, and perhaps link with it the requirement that physicians who participate in Medicare must take assignment in all cases.

A few years ago, I heard that the difference between what physicians charged the beneficiary and what Medicare approved, the amount beneficiaries had to pay out of their own funds, amounted to over $700 million. By now the figure has probably hit the billion mark. Additionally, because Medicare is so difficult to really communicate in all aspects, we may be better off with a vendor type program on the Part B side.

Another aspect of our problem with beneficiary relations and services in the Medicare program is the shared responsibility with the Social Security Administration. This relationship has made it difficult for contractors to know exactly what their role is.

When the Medicare law was first enacted, the Social Security Administration had the philosophy that the only face to face contact with the beneficiaries was to be done by the Social Security district office. The Social Security district office had the responsibility for outreach and for education of the beneficiaries. So the total beneficiary relationship was the responsibility of the district office rather than the Medicare contractor.

As time passed, people began going directly to the Medicare contractor, particularly the carriers, when they needed an answer as to the status of their claim or why a claim was denied. This information wasn't available at the district office. As beneficiaries moved in that direction, we began making the carrier more accessible by installing toll free lines. On the B side, lines were installed beginning October 1978, and we are now preparing for toll free access on the A side.

We've gone through an evolutionary process and as we move toward defining the contractor role in more specific terms we should establish what is expected of the contractor.

In closing, I'm pleased to tell you that the EOMB redesign proposal is coming out for the second and last round of comments. In the interest of trying to reduce jargon and help make the program more understandable for the beneficiaries, your ideas are welcomed.

MR. HANNA: Really just one thought to leave with us: I talked about the spirit and the letter, and I think you will all agree with me that the spirit was here this morning with respect to looking after the beneficiary.

I just hope that the flesh is willing. And let me suggest that you substitute the word "budget" for flesh; and I hope really that those of us in this room who are the management group, the decisionmakers, will not take the easy road saying, "Well, if we can save a couple of pennies on the unit cost, let's just dump outreach." I hope that none of us take that step, because I do not believe it would be in the interests of the program.

CLOSING REMARKS

Charles W. Stewart
California Physicians Service

Earl M. Collier
Deputy Administrator, HCFA

MR. STEWART: You've heard an awful lot of information the last couple of days. It's one of the first times I've ever had the opportunity to retrospectively look at the 1980's. Paul Willging opened this thing up by telling us that he had worked for eight administrators in five years. It wasn't clear if that was a threat to Len Schaeffer or not, but he did say that Leonard was the first one that had a clear view of where he was going.

Leonard came on then and described a future that showed consolidation of the contractor areas, reallocation of functions, new technology, increasing efforts to hold down costs of all kinds, increased competition, more stringent standards, more experiments, and increased pressure on the provider community for better quality. Now, that was the bad news.

The good news was that most of us won't be around.

The Under Secretary came next and told us that the Federal role won't diminish in the 1980's, but ours would.

It is presumed by almost all of our speakers that the competitively bid contracts are going to be the rule and not the exception in the 1980's, and perhaps that's true. If it's true, John Larkin Thompson told us that it is absolutely necessary that we find a way to get those kinds of contracts clearer and that a lot of work is necessary there. I tend to agree.

It is also clear from the speakers in the last two days that the jury is very much out on how effective such contracts are in controlling cost of benefits, and their long term impacts on both administrative costs and the beneficiary.

Les Alberthal and John Buelt told us that they concurred on the need for longer term contracts, with reduced risks on noncontrollable items. I will have to agree that I think that's appropriate, but I think it also ought to apply within the existing cost reimbursement contracts, to many of the supplier contracts we now find ourselves forced to rebid on much too frequent a basis.

We also need to see Mr. Buelt's project team report. Anybody who can do, in three or four months, what we've been debating now for years deserves a lot of scrutiny. I'm really somewhat concerned that it seems to be an unknown report as far as the majority of you are concerned. He commented that he had done a survey of some 13 various contractors and others, and that was the basis on which the report was done. My little survey during the cocktail hours is somewhat hazier, probably, than his; and therefore, did not disclose anyone who had seen the report and no one who would admit to having been an interviewee.

I would urge that you get the report. I would urge that you read it carefully, and I would urge that you comment on it just as carefully.

Mr. Schaeffer and Mr. Buelt both called for innovative systems approaches in order to hold down costs and keep our productivity improving, and I would have to agree that's the only hope for the future. However, it is also clear from the other comments that the current ACER and performance rating mechanisms tend to penalize innovation and create substantial risk for those

who are imprudent enough to innovate. We need to look at that, and we need to look at the role of the ACER as part of the bid evaluation mechanism, because that was clearly seen by a number of your speakers as questionable and worthy of considerable review. I think that's something that the Carrier Representative Group needs to do in the near future.

Ed Werner, perhaps, made one of the most important observations of the entire meeting, and that is that the program no longer fulfills the promises that it early on made to the beneficiary; that the constant shift of the costs of the program to the beneficiary over the last ten years simply has to be removed, or else we are going to have a circumstance where, no matter who is associated with Medicare, it's going to get a foul name with the public.

Duke, however, gave us lack of encouragement in that regard, because he described the 1980's as a time of restricted resources, and sounded a little like our governor in California.

Peter Fox, however, tended to corroborate that comment, and made what may be the three most important points of the entire conference when he said, first, that reimbursement practices and manpower planning have to be tied together if we are going to see any improvement. He also pointed out, second, that there is a significant drain of tax dollars to the aged and to the Medicaid programs, and if this continues at the rate it has, it will create profound social pressures and change. I suspect that is something we'd all better take to heart and use as a goad to improve our performance.

And the last point that he made, this third point, was that the demand for more and better data will create pressures on the payment mechanism and all other data resources that we are simply going to have to cope with; it's not going to go away.

Now, out of all that grew some considerable comment about too many doctors and the fact that this was raising costs. The alternative seemed to be to restrict access to the kind of training that physicians get prior to receiving their license. And I have to tell you that is very discouraging to me.

The kind of people who go through that training, who come out into the community, are very valuable people to us in our operation, with or without that M.D. after their name. Whenever you talk to somebody, you hear much talk about underserved areas, and so forth. There's no way that we are taking advantage of that over supply, if there is one, to see that those areas are served. I think there needs to be some innovative thinking on the part of the planners in this regard, as well.

I don't see why you can't train these people and then put in stringent exams so that only the very best of them are licensed to practice and thus control your people who are actually offering fee for service or other direct care. And then maybe provide an apprenticeship program so that a few more can be licensed if they go through an underserved area. However, a lot of thinking has to be done rather than simply shutting down a training structure that has now been built, and has cost us a lot of money to come by.

John Jansak told us about standards and the Washington Senators. I can tell John exactly what the problem was with the Senators, because I grew up in Sacramento. We also had a team called the Senators. Our pitchers were always looking for a consensus and our batters were affected by adverse hot winds blowing from the capitol.

I think we can all endorse the new performance standards, once we get them out, but I would have to say that Mr. Rinehimer's comments about the need to look at those things carefully and with a somewhat less than statistical eye, need to be given a lot of consideration.

I think also that they are like anything else that we've designed carefully, modeled, and given a lot of thought to, in that when we put them into practice, there had better be an awful lot of looking at the results before we begin to rely on them for decisions.

Don Nicholson talked about his program validation project, and asked us to be partners in applying it, and I think that's appropriate. However, I would point out again that this was one project where there was a real failure to work with the carrier community in the design prior to making that package available in the field. Participation will be slower to come as a result.

In summing up then, the key elements that we need in the 1980's are really almost exactly the same as were needed in the 1970's. We've got to have a real information exchange and planning effort between the government and the private sector, not the spotty approach we've seen in the past, and it requires a lot better followup if a good faith exchange is going to exist between us.

Consultation has improved, and I commend HCFA for the papers that they distributed here and for the conference, itself. We've got a long way to go. I hope we'll build on this conference and not abandon it again for four years until another election is in process.

The carriers and the fiscal intermediaries also have a lot to account for, and we need to be more consistent and respond much more completely when we are asked for comment. The carrier rep group frequently asks you to provide comment, agenda items and feedback. You're pretty poor. You don't provide that comment, in many cases, and, when you do, it's less than adequate. You've got to get better if you expect the government to regard you as the experts that you are.

We also need to truly take up Mr. Schaeffer on his statements that HCFA should favorably impact the private costs of health care as well as government's. If they manage to do that, it will be a real departure from the previous posture of taking the most favored position, and to hell with what's going to happen in the private sector.

I'm encouraged, however, by his statement that that's what he plans to do, because the shifting of cost to employers in the private sector simply can no longer occur now that government has assumed what Mr. Stark described as its increasing role in the health care field.

And, lastly, perhaps most importantly, it is clear that during the 1980's, we have got to find a way to keep the program's purpose of serving the beneficiary foremost in all our minds.

I'd like to thank Duke Collier and Leonard Schaeffer for the attendance of all the high level staff we've had here, and Mary Kenesson for the arrangements. I hope we can do it again.

MR. COLLIER: I'll be brief. I felt like I was up there all day yesterday, and I've said pretty much what I have to say. I wouldn't want to try to add to Chuck's first rate summary of this conference.

I think our expectations for the conference were somewhat mixed, but we'd hoped, at a minimum, that we would have in one room people who are concerned both from the contractor side and the HCFA side about the administration of the program, and that we would be able to stimulate a certain amount of communication between us, and I think that expectation has been fulfilled. Our hope will be that more and more communication will characterize the future.

If there is a final truth to be learned from this session and from anything else that I think we've been involved in, it is probably that these are difficult matters. They are not necessarily well understood in our program administration, either in the substance of what we do or the way in which we do it. They are not necessarily matters as to which there is a right or wrong at any given time, but only the best judgment that reasonably intelligent and reasonably well meaning people can hit upon after they've batted their heads against each other for a while.

You can look for more and more willingness on our part to bat our heads against yours, and our commensurate expectation that you'll be willing to come to the table with us.

I think that the substance of what we've touched on in this conference is a matter of greatest importance for the country in the next decade. I hope that we can continue to work in the spirit that I found, at least, in this two day period; a spirit of some good nature and relative open-mindedness.

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APPENDIX

DISCUSSION PAPER

HCFA POLICY STATEMENT
March 6, 1980

ANNUAL HOSPITAL REPORT

UNIFORM REPORTING

Background

Uniform reporting requirements have been developed with the recognition that current reporting systems have been inadequate. Traditionally, the Department has collected data about cost and volume of services using a system which gives hospitals a great deal of flexibility in how they report costs. That flexibility was appropriate in the early years of the Medicare and Medicaid programs, given the state of the art in hospital accounting.

However, as the programs grew, costs increased and accounting became more sophisticated. Congress recognized the need for uniform reporting and acted in 1974 to pass the Health Planning and Resources Development Act (P.L. 93-641). Section 1533(d) of the Act required the development of uniform systems of cost accounting, reporting, classification, and rate setting for institutional health care providers. The Department was then charged with developing uniform reporting and accounting systems. Simultaneously, several States passed legislation to adopt uniform reporting systems. In 1977, Congress mandated implementation of a uniform cost reporting system in the Medicare Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142).

Why Uniform Reporting?

Uniform reporting is necessary to improve management of our reimbursement programs. Current reporting lacks comparability among providers for similar services because of the flexibility the providers now have in reporting costs. This makes it difficult to judge the efficiency of hospitals and to compare the cost of services furnished within the hospital or among hospitals.

Under the current reimbursement system, hospitals normally report their costs on the basis of their own "responsibility" accounting system. This means they organize their revenue and expense reports according to organizational units that produce the revenue and incur the expense. Each hospital is organized somewhat differently, therefore, the costs are organized differently. Further, there are not precise or uniform definitions of what types of costs can be included in a particular cost center and no standard units of measure. Consequently, there is no adequate way to precisely determine the cost per unit of service, to compare these costs across hospitals, and to adequately measure productivity. Finally, current reporting permits hospitals the flexibility to divide or combine like Departmental costs and to allocate overhead costs according to the statistics recommended on the cost report, or other statistics, if approved by the fiscal intermediary. This affects HCFA's reimbursement and can result in a hospital receiving more or less reimbursement under the cost reimbursement system employed for the Medicare program.

We need a better reporting system if we are to develop meaningful comparisons among hospitals and establish a better data base for reimbursement reforms. That system must produce data organized on the basis of "functional" reporting. This means that hospitals would report their revenue and expense according to the uniformly defined activities which generated the revenue or incurred the expense rather than the organizational units unique to a particular hospital. There must also be a standard definition for the types of costs that can be included in a particular cost center so that costs can be reported and reimbursed uniformly.

Finally, there must be a standard unit of measure for all revenue producing departments or cost centers. These standard units of measure will permit the comparison of the cost and charge per unit of service across hospitals. It is recognized that this cost information must be integrated with case mix and input price information as comparisons are made.

A system with these features would mitigate the degree of discretion available to hospitals in reporting costs, to ensure that the data reported by hospitals is comparable across institutions furnishing similar services.

Uses

The Annual Hospital Report will provide data for a large number of users. For example, the Health Care Financing Administration (HCFA) and the Department will use the data to develop a more rigorous and equitable reimbursement system for the Medicare and Medicaid programs. Moreover, it will improve the capacity to detect abuse and waste, and provide for year to year and interinstitutional comparisons and monitoring of hospital expenditures, productivity and utilization of services. It also provides a tool in establishing more refined limits on hospital cost and reduce the need for many of the current hospital surveys.

State agencies will be able to identify patterns of utilization and evaluate effectiveness of State and regional programs. States will be assisted in carrying out State program objectives including: providing the necessary data for policy and reimbursement decisions at the State level, reducing redundant data collection activities, and obviating the need for the development of 50 different systems across the United States.

Hospitals will be provided with comparative information which will help them identify opportunities to make more productive use of their resources. They will be able to compare the performance of their own institutions against that of similar situations (improving management awareness and resulting in cost savings) and be better able to evaluate the competitive position of the institution.

Other users, such as health planners and lending institutions, will benefit from this data. Health planners will be able to gather an inventory of health services, find cost efficiencies and evaluate financial feasibility. Lending institutions and investors will be able to determine the financial viability of projects for debt financing.

Cost

In analyzing the effect of this proposed regulation on hospitals, we assessed the cost and burden of seven alternatives out of the literally hundreds of variations that could be devised. The alternatives range from total conversion of the hospital's day to day accounting system to retention of the current Medicare reporting system. Although the first of these alternatives (total conversion of a hospital's accounting system) cannot be required by HCFA and the last is contrary to the mandate of P.L. 95-142, we included them for costing purposes since they represent both ends of the spectrum and thus indicate the entire range of marginal cost/burden from $208 to $0 million for the first year.

Under the alternative we selected, the total start up costs for all hospitals would be $19 million, and the annual operating costs $37 million, for a total of $56 million in the first year. The total cost in the first year would be only 0.2 percent of the $25 billion we paid to hospitals in 1978 and only 0.079 percent of the $70.9 billion hospitals received from all sources in 1978. For the average hospital which billed Medicare and Medicaid $3,589,000 in 1978, this proposal would add only $5,300 yearly to its operating costs.

DISCUSSION PAPER

THE HEALTH CARE INFORMATION SYSTEMS OF THE 1980's

HCFA'S PERSPECTIVES AND INITIATIVES

March 10, 1980

I. Introduction

In a time when excessive inflation translates into reduced available resources, the challenge to all of us involved in the health care system is to work together to efficiently and equitably manage the system so that it may continue to finance and provide quality health care services to those that need them.

The health care industry as a whole must act to rationalize the existing system if the demands of the 1980's are to be met. This paper discusses possible approaches to improving the health care information system to support a more efficient use of health care resources by both private and Federal beneficiaries.

Existing information systems need to be examined in light of anticipated demands for information in this decade. The Federal government and private industry need to collaborate in developing and implementing a plan for simplifying and unifying our health data and information systems throughout health care industry. The result of such coordination shall be a reduction in the present reporting burden on all providers, better information and communication for health care managers and planners at all levels and ultimately a more effective health care system.

HCFA is committed to making a major contribution to health data management and the health financing systems of the 1980's.

HCFA's efforts will focus on participating in and supporting the development of more efficient approaches to the collection, dissemination and management of data required to support our nation's health care system.

Our objectives include:

- o establishing common standards of communication among the users, and between the providers and users;
- o promoting cost effective, alternative systems for capturing and disseminating data to multiple users; and
- o movement towards paperless transactions.

Initially, our targets for improvement will include:

- o incompatible communication standards within the system;
- o redundant or burdensome reporting; and
- o technically outdated or paper oriented information management systems.

We will be promoting regular dialogue among users and providers of health data to achieve these objectives.

Through coordinated activities in these important areas, improvements will be realized in terms of:

- o improved accuracy of recorded and reported data
- o improved timeliness of recorded and reported information
- o reduced costs for data entry, collection and processing
- o reduced reporting burden on the provider
- o reduced processing time

II. Background and Perspectives

A. Industry Overview

- o Within the past 20 years, health care has grown into a major industry. In 1960, total spending for health in the United States amounted to $27 billion. By last year, it had increased to $182 billion -- a rise of almost 700 percent.
- o Health care now represents ten percent of the GNP.
- o Similarly, in a little more than a decade, government financing of health care has turned into big business. HCFA enters the decade of the 1980's with an annual budget of almost $48 billion which finances about one quarter of the nation's total health care expenditures. HCFA programs have become the largest purchasers of health care services in the free world.
- o These figures represent a sharp contrast to the expenditures of the Medicare and Medicaid programs when they first began in the mid 1960's. For example, in FY 1966 the Medicare and Medicaid programs spent $3 billion in health care benefits.
- o The creation of HCFA in 1977 brought together the Medicare, Medicaid and related quality assurance programs into one administration. Since then, HCFA has become the focal point for Federal government financing of health care.

Today, HCFA is responsible for financing quality and timely health care services for its 47 million beneficiaries -- the poor, the aged, and the disabled.

B. Growth of Health Data Information Systems

When government financing of health care began, operations were basically patterned after other health care insurers of the day, adopting many of the existing reimbursement approaches.

As government provision and financing of health care services evolved, programs were added, and requirements were changed. The health care industry refined its operations to meet growing government demands. The net result of rapid growth in the government purchase and provision of health care and associated information requirements has been the creation of a complex and relatively inefficient set of information systems.

Initially, when a government program changed aspects of its operations, or a new program led to additional information requirements, the impact on the health care industry was relatively insignificant. But as the government sector expanded, so did the data and information handling needs. Likewise, private sector information requirements have increased. As a consequence, information collection and use represents a multi-billion dollar business which has not been systematically conceived and developed and most likely contributes to aggregate health care system inefficiencies. Such inefficiencies absorb dollars which could be better spent on health care services or other social needs.

Today, efforts by any one of us to revise some aspect of this system can result in major disruption throughout the health care sector and may not necessarily benefit the industry as a whole.

This paper proposes a series of initiatives which will rationalize existing information flows and reduce the burden and costs associated with data acquisition as well as improve the utility of resultant data.

C. HCFA Management Initiatives

The creation of HCFA brought together five different programs from three agencies. HCFA programs include:

- Medicare
- Medicaid
- PSRO
- Provider Certification and Standards
- Quality Control

To facilitate effective administration of HCFA programs, and to promote more cohesive decisionmaking across these programs, HCFA established an administrative framework which realigned its management along functional lines. The realignment provides a framework for promoting consistencies across its programs.

In the past, as a result of differing philosophies and different histories, HCFA's programs often operated in different ways while seeking similar results -- the purchase of quality services for beneficiaries.

As a result, providers have been confronted with conflicting or duplicative paper work and other requirements. The public, beneficiaries, and Congress have been confused about programs and concerned about cost efficiency.

With HCFA's administrative structure now in place, we should work to achieve management and operating efficiencies in the way our programs operate and in the way data is collected.

III. Initiatives

A. HCFA Role

As the nation's largest financer of health care, the activities HCFA undertakes and the policies which HCFA implements will significantly impact others in the system. HCFA must ensure that its policies and actions promote efficiency and quality within the total health delivery system. This requires a constructive relationship with providers and third parties involved in that system.

Efforts to improve information systems will also encompass HCFA's responsibility to implement uniform reporting as required by Section 19 of P.L. 95-142. 1/

B. Assumptions

The characteristics and conditions which we assume will continue include:

- o Quality assurance and planning activities will continue to improve;
- o Reimbursement to physicians will be predominately fee for service in the near term, but other systems will continue to be tested;
- o Attempts to reform institutional reimbursement will continue, e.g., case mix, prospective rates, etc.;
- o We will continue to prepare for enactment of some form of national health plan.

We also assume that the data, information, and methods of communication which comprise the systems necessary to operate and manage HCFA programs are now, and will continue to be, essentially similar to those of others in the business of financing health care.

We further assume that by adopting common standards of communication the system as a whole will benefit in terms of improved timeliness, quality and utility of data and reduced burden on the provider.

C. Preliminary Initiatives

1. Common Standards of Communication
HCFA programs will be moving toward common standards of communication including:

   - o common data sets
   - o common definitions
   - o common coding systems
   - o common identifiers

1/ Section 19 of P.L. 95-142 requires the Secretary to implement by regulation, uniform reporting of cost, capital assets, rates, bill and discharge for all classes of providers. HCFA has been delegated this authority.

Our initial focus for implementing common standards of communication has been primarily directed at the institutional sector of the industry. Many years of effort have already been devoted to developing and testing these common standards in the hospital sector. Initial work progressed in this area because expenditures for hospital care represent a large percentage of our budget: $26 billion in 1980, or about 58 percent of the HCFA's budget.

Other initiatives include common procedure labeling and uniform physician and supplier billing.

2. Alternatives for Capturing and Disseminating Health Data

We hypothesize that by employing common data elements, definitions and coding systems, along with improved technology, the reporting burden to the provider will be reduced while utility to users will increase through improved quality, timeliness and compatibility of reported data.

Toward this end, we have begun assessing elements of health care information systems which are similar and dissimilar, including:

- o data elements,
- o data flow, and
- o information needs of users.

For the hospital sector, it is apparent that a variety of users require markedly similar data within two categories of information:

- o patient information including claims data and clinical data which is recorded and reported on a daily basis;
- o facilities data, including cost information and utilization statistics which is recorded and reported on an annual basis.

a. Patient Health Care Information

We are exploring alternative approaches to capturing and disseminating patient information.

One approach HCFA is currently testing is a conceptual model for linking hospital bill and discharge data.

The objectives of this system include (1) reducing unecessary burden on the provider; (2) improving quality and timeliness of data; and (3) meeting the needs of multiple users.

These systems build on standardized communication tools (codes, definitions and core data sets) being in place in hospitals throughout a State. The model includes the following basic functions:

- o integration of bill and discharge data in the hospital through uniform input;
- o transmission (preferably electronically) of the integrated data to a central clearinghouse or directly to users;

- o dissemination of appropriate data to authorized users including thir party payors, PSROs, HSAs, State statistical agencies, and HCFA; an

- o compilation of State and local comparisons and other managemen information for hospitals.

This concept of integrating discharge and bill data suggests a substan tial but mutually beneficial departure from the existing collection an processing systems in existence today. But in spite of the benefits, it i already clear that changing the traditional approach to the recording handling, and flow of data will not be easy. In addition to encountering th inevitable issues attendant to change, the data systems must grapple with som of the key issues in health care today, including personal privacy and confi dentiality; access and ownership of data; and political and jurisdictiona control.

HCFA has recently awarded demonstration grants to organizations to tes the integration of health information in New York, Maine, Vermont, Minnesota, South Carolina and Missouri.

We believe there are a variety of approaches which will improve anc facilitate data integration and automated transmission. HCFA is encouragin organizations which are interested in testing alternatives to contact us.

b. Cost and Facilities Information

- o HCFA will be publishing a Notice of Proposed Rulemaking announcing the Annual Hospital Report (AHR). The AHR will include requirements for reporting cost and facilities information for hospitals.

- o Basic features of the Annual Hospital Report are described below:

  - . meets uniform reporting requirements of Section 19 of P.L. 95-142

  - . consolidates existing/overlapping reporting

  - . incorporates unmet needs of health planners, others

  - . developed through intensive consultation with industry, Congress, and other agencies within HEW

  - . based on standard definitions

  - . will provide accurate comparisons across hospitals

  - . will be automated to the maximum extent feasible, to provide rapid feedback

  - . will serve as a basis for reporting to multiple users

    - Medicare

    - Medicaid State agency

- State and local health planners
- State Centers for Health Statistics
- State rate setting agencies

c. Linking Data Bases

- o As a long range objective, HCFA would like to explore approaches to linking and concentrating AHR information with case mix data.
- o Ultimately we would like to see comparable and compatible information generated from providers at all levels of care ranging from acute, to long term care, to ambulatory.
- o We would like to work closely with industry to develop these approaches.

d. Quality of Information

Through all phases of development of these systems, maintaining and improving quality assurance of data input and handling will be a critical feature.

e. Other Directions/Initiatives

HCFA intends to develop similar standardized systems for all providers, including:

- o long term care facilities
- o home health agencies
- o health maintenance organizations
- o physicians

3. Collaboration with the Industry

HCFA is committed to involving the industry as we develop this new system.

This is one of a series of discussion papers we will be sharing with the industry to specifically solicit the industry's comments and recommendations on our directions and initiatives. We encourage you to comment on the issues presented in this paper.

Please forward any comments or recommendations on this discussion paper to:

James M. Kaple
Acting Director, Office of Research,
Demonstrations and Statistics
Room 5054
Mary E. Switzer Building
330 C Street, S.W.
Washington, D.C. 20201

Please reference the title and date of discussion paper in your comments.

DISCUSSION PAPER

OPERATING FRAMEWORK FOR HCFA

PROGRAM ADMINISTRATION

March 10, 1980

Introduction

This discussion paper is to set forth major HCFA program administrative objectives for improving the operating framework of the Medicare and Medicaid programs. The Health Care Financing Administration intends to strengthen the operating framework for these two programs to achieve improved services to beneficiaries and providers, more accurate and timely program payments, and reduced costs. These efforts must evolve towards increasing the compatibility and improving the interface of these two programs with the health delivery system and private health insurers.

Major reliance has been placed on the States in Medicaid and private contractors in Medicare to carry out the day to day operational administration of the programs. HCFA views these relationships and responsibilities to be appropriate and they will be continued. HCFA has no plans for assuming direct responsibility for operations. It does plan to take positive steps with the States and contractors to modify and improve the operational framework.

It is important in this context to emphasize that HCFA recognizes basic and fundamental differences between Medicare and Medicaid which will continue to affect the operational framework. Medicaid is a State administered program funded with both State and Federal funds, whereas, Medicare is Federally administered and Federally funded. The Medicaid program and its coverage varies according to the options exercised by the several States, and includes benefits, such as prescription drugs and ICF care, which are not available under Medicare. On the other hand, the Medicare program and its coverage is national in scope and is uniform. The two programs differ also in the beneficiary/eligible population addressed and in the basis for qualifying or establishing entitlement.

Although programmatically there are major differences, there are also significant areas of functional similarity and need for compatibility of information. Both deal essentially with the same community of hospitals, physicians, and other providers. They are both high workload, ADP oriented programs which rely extensively on contractors, fiscal agents and other support services. There is a great commonality of need with respect to procedure codes, uniform bills, uniform cost reports, common audit, payment screens, utilization, medical necessity, fraud and abuse. Both programs are heavily involved with the health delivery system as they address the same basic issue of financing the health care needs of their client population.

In addressing the operational framework of the two programs, the differences and similarities must be taken into account and, as well, the relationship of the two programs to private insurers. Our objectives will be to maximize common processes, policies, procedures, and information requirements. Major initiatives will be undertaken with respect to performance standards, competitive procurement requirements, implementation of MMIS, financial management, budget estimates, contractor configuration, selection of contractors and fiscal agents. Improved standards of performance will be developed and issued for Medicare Part A and Part B and for Medicaid.

The scope of the activities and objectives for addressing the operational framework are set forth in greater detail in the following section of this discussion paper, which addresses Medicare objectives. A discussion paper on Medicaid will be forthcoming shortly and will be available for distribution to all parties in May at the time of our annual Medicaid directors' conference.

Comments and recommendations from interested parties will be appreciated. Comments should be submitted to Mildred L. Tyssowski, Director, Bureau of Program Operations, Room 300 East High Rise, 6401 Security Boulevard, Baltimore, Maryland 21235.

Medicare Objectives - General Background

There have been significant changes in Medicare program administration over the years with respect to technology, organization and program acceptance. The initial administrative structure has served well in meeting the original needs of the program. Reliance on the private sector contractors has been quite successful in the administration of the program and there is no demonstrated need for changing this partnership.

However, the intense pressure of the evergrowing workloads experienced, the increasing complexities in policy and procedures, the new initiatives to contain health care costs, all have created a current environment that demands a new look at the administrative structure in Medicare. There is a real need to establish now a framework of operations that will go directly to simplification of process and procedure, to improvement in the timeliness and the accuracy of program payments, to improvement in the quality of service to providers and beneficiaries and to better understanding and more uniform application of program policy. To address these needs and work towards the establishment of an operational framework which will more effectively serve program needs in the 1980's and future years, the present configuration of Medicare contractors must be reassessed.

A major consideration in these deliberations is the desirability of combining the administration of Medicare Part A and Medicare Part B in a single contractor structure. The initial separation of Part A and B was an accident of the legislative development of the Medicare program. It is unlikely such a split would occur if the law were written today. The consolidation of Part A and Part B would provide for greater effectiveness and consistency in program administration and considerably enhance the program's capability to accommodate and implement legislative changes in the future.

There are many crossovers between the two parts of the program and combining them under a single contractor for a defined geographic area would decrease the number of Medicare contractors and should reduce administrative costs, provide for better utilization review and control of program payments, provide for better coordination and flow of information on program activity and improve the exchange of data with Professional Standards Review Organizations (PSROs), Medicaid and other agencies, public and private. Combining A and B would also simplify beneficiary access to and understanding of the Medicare program. There is also a need for concerted efforts to assure an effective interface and operating relationship with PSROs in light of their lead responsibilities for addressing medical necessity and utilization.

In the President's fiscal year 1981 budget, a total of $719.6 million is estimated to be spent on Medicare contracts. Except for funding a few experimental contracts which were awarded competitively, this money will be spent on negotiated contracts, with the contractors being reimbursed on a cost basis. For no other program in the Federal government is such

a high dollar volume of contracts awarded on a noncompetitive basis. Furthermore, in the Part A program the contractor is selected by the providers that it services for Medicare payment. Competing Medicare contracts should bring innovations to claims processing systems, and facilitate the selection of new contractors when turnover occurs, and result in improved service at less cost.

This discussion paper outlines a strategy and approach for addressing the needs for change in the operational framework for administering the Medicare program. The goal of the Health Care Financing Administration is to establish an improved Medicare contracting structure which will best serve long range program objectives.

Recent Reviews of the Medicare Operating Framework

In 1978, an internal HEW study was carried out which concluded basically that administration of Parts A and B of Medicare should be combined, contracts should be let competitively, and contractors should be reimbursed on other than a cost basis. An independent study conducted by the General Accounting Office (GAO) for Congress in 1979 supported some of the same conclusions, and encouraged HEW to proceed with competitive contractor experiments. The President established, in September 1979, a Management Improvement Council (PMIC) made up of leaders in private industry to advise him on ways to improve management of the Federal government. A subcommittee was established on Health Care Costs which took as one of its first assignments a review of our Medicare contracting strategy. Some of the major conclusions as reflected in their draft report supported competition in the selection of contractors; the reduction in the number of Medicare contractors; the combination of the administration of Parts A and B of the program under one contractor; and the development of contractor geographic areas based on optimum workloads.

Contracting Strategy

Based on these assessments and our experience to date with the existing structure, we have formulated a contracting strategy for Medicare which over the next five to ten years will gradually reduce the number of contractors. Our strategy is designed to achieve more accurate and timely program payments and improved services to providers and beneficiaries at reduced costs to the government. It also addresses the need for a simplified framework for program administration so that beneficiaries and providers of services will better understand the operation of the program and so that efficiencies can be introduced more easily, e.g., common claims forms, more uniform cost reports, common diagnostic codes, common procedure codes, more effective prepayment and postpayment screens, automated billing and data reporting techniques.

The four basic elements in our Medicare contractng strategy are:

1. Establishing standards of performance incorporated in the contracts. These standards could then be used for assessing monetary damages or taking contract action for poor performance or making incentive payments as a bonus for superior performance. It is not now possible to assess liquidated damages or make incentive payments in the cost contracts.

2. Selecting and awarding contracts through competition and on other than a cost basis.

3. Combining in a single contractor for the territory administration of both Medicare Part A and Medicare Part B.

4. Reduction in the number of contractors by establishing contractor territory on the basis of geography, workload, and potential for administering new health insurance legislation.

In pursuing this strategy we will be employing a multi-faceted approach. We will continue our experimental initiatives to gain additional experience with other contracting modes, functional arrangements, and methods of reimbursement for administrative costs. This will assist us in further refining our contracting strategy. Administrative actions, in the framework of present law, will be taken in pursuit of these objectives. Contractor performance will be monitered closely against published standards and contract action will be taken, as appropriate, where performance does not meet the standards established. We will also continue our efforts to seek legislative changes to provide the Secretary with greater flexibility in the selection and reimbursement of contractors.

Administrative Initiatives

Our administrative actions under current authority will be directed primarily toward contractors whose performance is unsatisfactory. Performance standards have been published for Part A contractors and will be published soon for Part B contractors. Contractors who fail to meet the standards published will risk termination of their contract or modification in the scope of their service. This activity will be ongoing in nature and will have the result of eliminating poor performers. Under our existing performance measurement system, we have identified and put on notice a number of contractors whose performance is not satisfactory. These contractors are now working to meet specified performance objectives established by our regional offices. Failure to meet these objectives may result in adverse contract action being taken.

Additional administrative actions planned involve the announcement and designation of a single intermediary to serve all home health agencies (HHAs) in a given State. This action is consistent with congressional concern for improving HHA program administration and the presumption that by having fewer contractors involved in the administration of the program, greater expertise in handling home health reimbursement and utilization issues can be achieved. The present authority of providers to select their contractor in the Part A program has resulted in a widespread dispersion of providers serviced by the large Part A commercial insurers. Health Care Financing Administration plans to work with these organizations to reduce the wide geographic dispersion of the providers they serve through some consolidation of their activity. We will also be working with the Blue Cross Association which subcontracts basic intermediary functions to the local Blue Cross Plans to reduce the number of subcontracting Plans in a single State where it is in the program's interest to do so.

Experimental Initiatives

Under the experimental authority contained in section 222 of the 1972 amendments, we have implemented three competitively let fixed price contracts in Medicare Part B in Maine, Illinois and upstate New York. We also initiated a Part A experiment in Missouri and a combined Part A and Part B experiment in the three State area of Colorado, Utah and Wyoming. In the last two instances, litigation is in process and future action is pending appellate court decisions. In the Illinois experiment, litigation was also involved and the Secretary's position prevailed. We anticipate a ruling by the circuit court of appeals in the Missouri experiment in March or April. In the Colorado, Utah, Wyoming experiment, briefs are to be filed with the circuit court of appeals in mid-March. (Details with respect to these experiments will be found in Tab B.)

These experiments have demonstrated that competition does result in administrative savings (net projected at $34.8 million in Illinois and $15.6 million in upstate New York). They have also identified for us specific transition problems which will have to be overcome in future procurements through revision in the procurement process by strengthening implementation performance requirements, closer monitoring of performance, and better testing of operational capability to assure the least disruption in program services to beneficiaries and providers. To facilitate future transitions, our experiments have also demonstrated the need for uniform national procedure codes, uniform bills/claims, and a consistent approach to locality structures and to specialty recognition for establishing profiles and screens. We are hopeful of favorable decisions in the pending appeals as we are most anxious to experiment in Part A and also in a combined Part A and Part B operation. We will have to reassess the current situation when the decisions are rendered.

We are giving consideration to a possible additional experiment in Part A that would separate out the audit and reimbursement functions; we will propose a contract for audit and reimbursement on a cost basis, with the claims processing function conducted on a fixed price basis.

A combined Part A and Part B experiment is required to determine the degree we can achieve integration of common data files and crossover information, and to learn how a combined operation should be best run. To the extent that good software systems can be developed to combine Parts A and B, there is a good potential for improving the accuracy of program payments. Finally, we will work toward a contract to combine the administration of Medicare A and B and Medicaid in a State. This project will be of importance in planning and preparing for national health insurance legislation.

Model Configuration

Currently, there are 119 Medicare contractors with 76 in Part A and 43 in Part B. Administrative costs in FY 1981 will run about $719 million including a contingency fund. The operating estimates for Part A are $243 million and for Part B are $456 million, and a contingency fund of $20 million. The total claims workload to be processed is at 208 million claims (Part A, 42 million and Part B, 166 million). In addressing the current configuration to determine what our optimum objective should be, we have taken into account a number of factors including the following: (1) maintain consistency with HEW regional boundaries; (2) use of States as basic building blocks; (3) achieve, where

possible, for each contractor territory a workload of four to ten million claims; (4) maintain enough small contractors to assure entry level for new contractors; (5) combine Medicare A and B; (6) assure administrative cost savings; and (7) improve management of program payments and improve service to beneficiaries and providers.

With these critical elements in mind, we have developed a "model" configuration of Medicare contractors which would number from 50 to 60 with each contractor administering both Parts A and B in the defined territory. An underlying principle in this configuration structure is that of geographical integrity, meaning that all providers and beneficiaries in the defined geographical area will be served by the single contractor for that area. In the more populous States, there may be a need for two contractors. In less populous areas, multi-State contractors would be considered. A model of 52 contractors is attached for illustration and discussion purposes (Tab A).

Reduction in the number of contractors and consolidation of service areas on a geographic basis promises significant cost savings through economies of scale and reduced overhead costs, and the opportunity for improvement in the quality of services and in beneficiary and provider understanding. We estimate that such a configuration, when fully implemented, would result in administrative cost savings of $124 million annually on an ongoing basis, measured against current costs.

Implementation Considerations

Implementation of a new configuration of contractors must be carefully planned and be carried out in a manner consistent with our administrative and operational capabilities and least disruptive to beneficiaries and providers of service. We believe implementation would have to be phased in on an incremental basis over a period of five to ten years.

Upon enactment of the necessary legislation, hopefully in 1980 or 1981, we would announce the specific incremental schedule of implementation. It will be a major procurement undertaking and it will be critical that we proceed consistent with our administrative capabilities and to assure the least program disruption. In this regard, it is important to note here that we do not propose frequent turnover in contractors. Rather, with some possible exceptions in the smaller jurisdictions, we contemplate contract terms in the range of five years with built in options for extension and renegotiation of price at the end of the first three years. We plan for the competitive selection of all contractors and believe reimbursement must be on other than a cost basis, e.g., overall fixed price with adjustment for workload volume changes, fixed rate, and that the contracts specifically include performance standards which address quality, accuracy and timeliness of payments.

Legislative Needs

Legislation was introduced last year which sought to (1) remove the existing requirement for the Secretary to reimburse on a cost basis; (2) permit organizations other than health insurers to serve as Medicare contractors if they can demonstrate their experience and capability to handle Medicare contracts; and (3) eliminate the nomination process and permit the Secretary to select contractors without regard for provider preference. We cannot, except on a limited experimental basis, pursue competitive selection and reimbursement on other than a cost basis until the statute is amended.

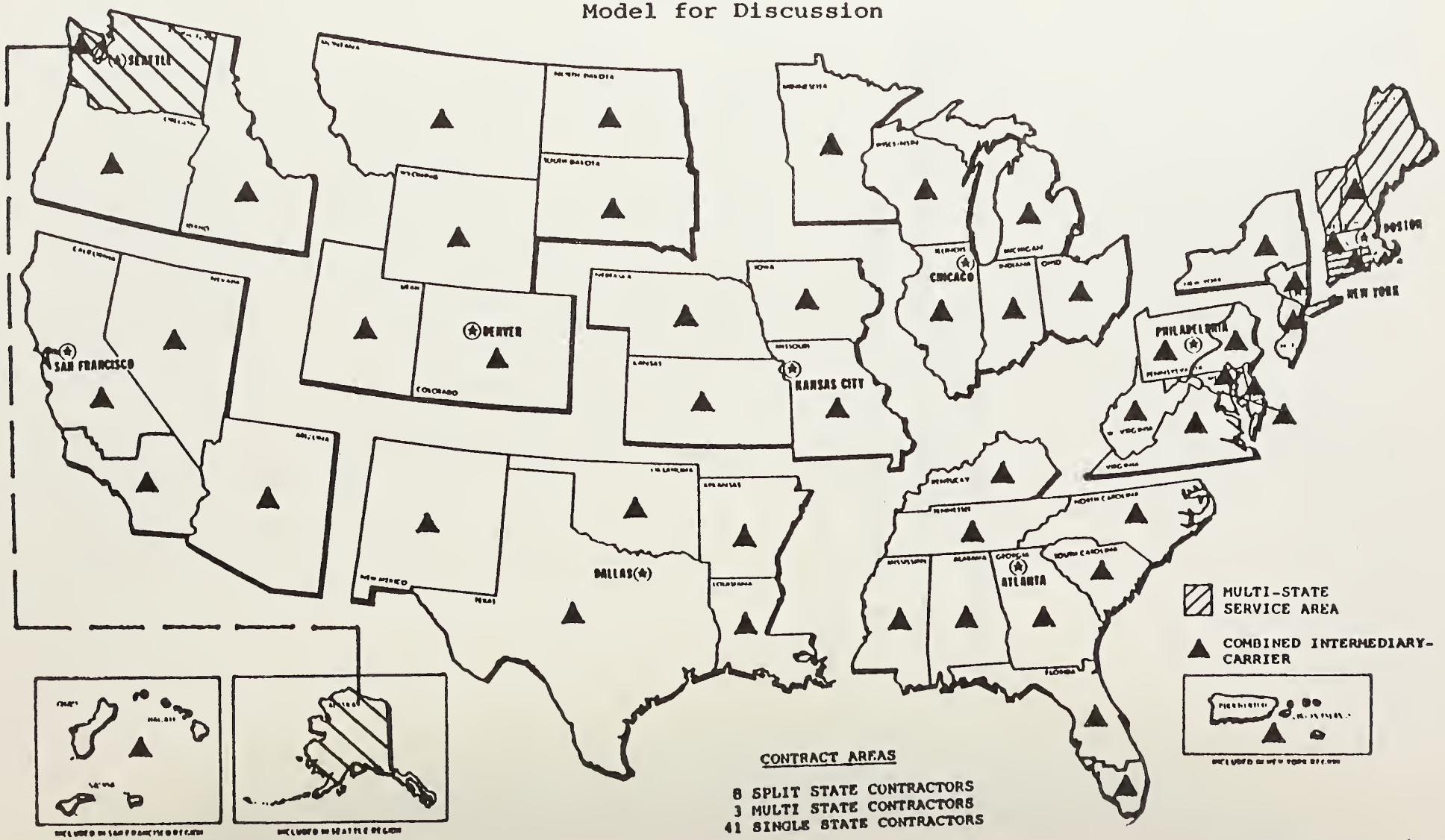
TAB A

1. 52 Contractor Configuration Map -- Model for Discussion
2. Combined A/B Workloads for 52 Contractor Configuration
3. Part A Intermediary Workload Distribution
4. Medicare Part B Carriers

HEALTH CARE FINANCING ADMINISTRATION

(52) CONTRACTOR CONFIGURATION

Model for Discussion



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HEALTH CARE FINANCING ADMINISTRATION

(52) CONTRACTOR CONFIGURATION

Model for Discussion

Area	FY 1985 Projected Workload (in thousands) A	B	A/B
REGION I			
Maine/ New Hampshire/ Vermont	1,338	4,290	5,628
Massachusetts	2,945	8,898	11,843
Connecticut/ Rhode Island	1,402	6,596	7,998
REGION II			
Upstate New York	1,965	7,698	9,663
Metro New York	4,086	15,996	20,081
New Jersey	1,994	11,809	13,803
Puerto Rico/Virgin Islands	566	1,579	2,145
REGION III			
Eastern Pennsylvania	4,226	9,527	13,753
Western Pennsylvania	3,027	6,824	9,851
Delaware	178	697	875
Maryland	1,105	3,919	5,024
District of Columbia	130	1,073	1,203
Virginia	927	4,336	5,363
West Virginia	522	2,385	2,907
REGION IV			
Kentucky	823	1,878	2,701
Tennessee	1,103	5,023	6,126
North Carolina	1,403	5,475	6,878
South Carolina	747	2,977	3,724
Georgia	1,395	5,916	7,311
Alabama	910	4,300	5,210
Mississippi	762	2,864	3,626
North Florida	1,607	14,204	15,811
South Florida	1,314	11,608	12,922
REGION V			
Illinois	3,062	5,976	9,368
Indiana	1,234	4,728	5,962
Ohio	2,632	13,128	15,760
Michigan	2,691	14,012	16,703
Minnesota	937	3,926	4,863
Wisconsin	1,173	5,059	6,232
REGION VI			
Arkansas	503	3,659	4,162
Louisiana	655	2,637	3,292
Oklahoma	413	2,824	3,237
New Mexico	239	1,180	1,419
Texas	2,041	14,675	16,716
REGION VII			
Iowa	715	2,499	3,214
Kansas	502	2,756	3,258
Missouri	1,179	5,625	6,804
Nebraska	229	1,281	1,510
REGION VIII			
Colorado	645	2,815	3,460
Utah	241	1,102	1,343
Wyoming	63	230	293
Montana	198	559	757
North Dakota	123	760	883
South Dakota	160	528	748
REGION IX			
Northern California	2,566	12,123	14,689
Southern California	3,510	16,588	20,098
Arizona	513	3,172	3,685
Nevada	354	645	999
Hawaii/Guam/American Samoa	161	1,174	1,335
REGION X			
Oregon	681	3,069	3,750
Idaho	221	756	977
Washington/ Alaska	958	4,054	5,012

TAB B

1. Current Experiments

Current Experiments

1. Maine (Part B)

This fixed price procurement was awarded for a total contract price of $5,285,000 which represents a net savings of $772,556 when compared with the projected expenditure under a cost reimbursement contract. The contractor's general performance has been satisfactory. The experimental contract initially covered the July 1, 1977, through September 30, 1980, period, but negotiation with the contractor has been completed for the extension of the contract an additional year per the optional provision available to the government in the original procurement.

2. Illinois (Part B)

This fixed price procurement was awarded for a total contract price of $41,800,000 which represents a net savings of $34,790,232 when compared with the projected expenditure under a cost reimbursement contract. The winning contractor assumed responsibility for an entire State which was previously serviced by two different contractors. This contract became fully operational July 1, 1979, and extends through September 30, 1983. The contractor has encountered operational problems which are now being addressed and the contractor will be subject to assessment of liquidated damages for poor performance in the October-December 1979 quarter.

3. New York (Part B)

This fixed price procurement was awarded for a total price of $20,296,150 which represents a net savings of $15,593,270 when compared with the projected expenditure under a cost reimbursement contract. The winning contractor assumed responsibility for geographical area previously divided among three different contractors. This procurement became fully operational on October 1, 1979, and extends through September 30, 1982.

4. Missouri (Part A)

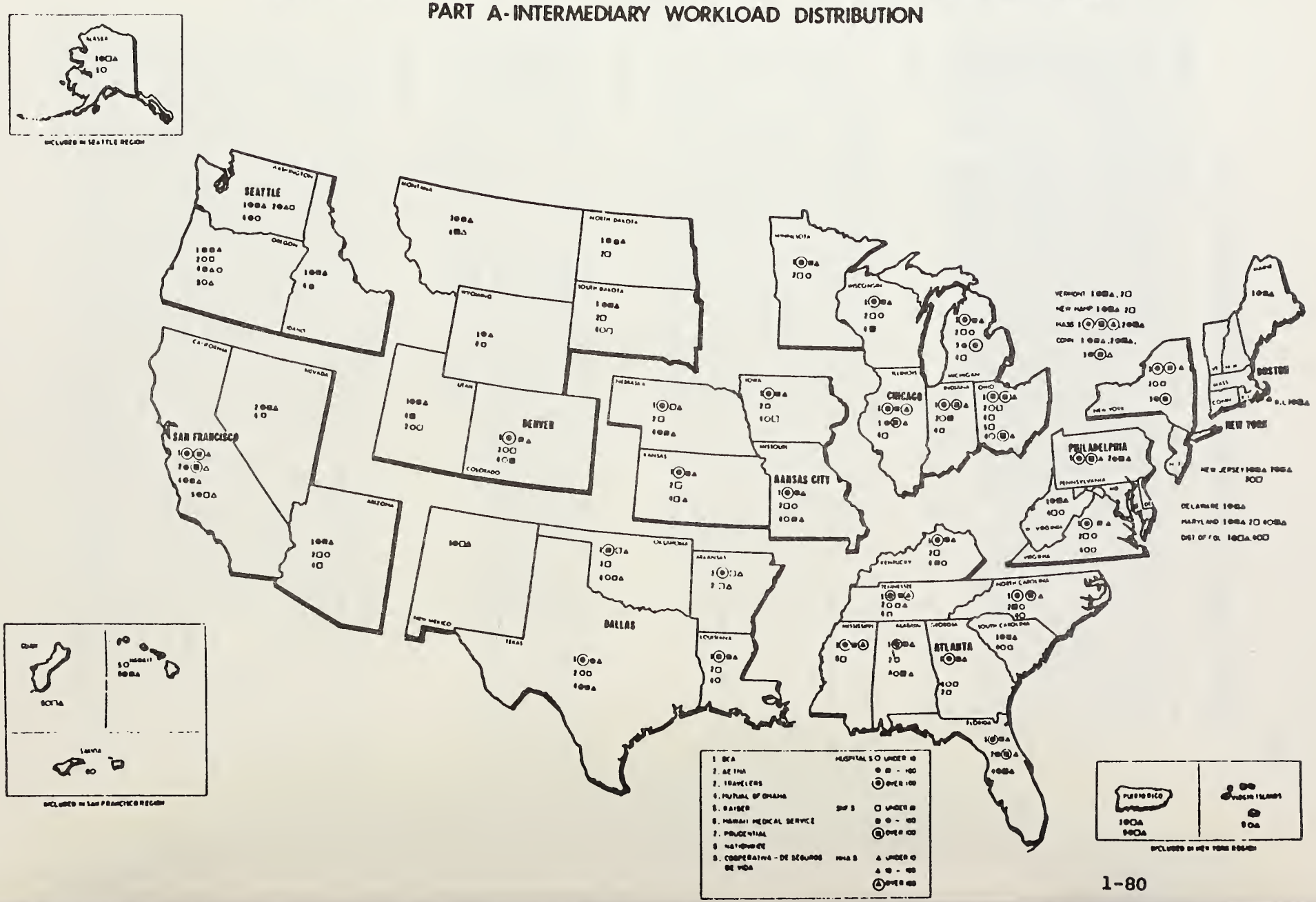
The first fixed price competitive bid contract under Part A was to be awarded July 2, 1979. The term of the contract was to be January 1, 1980, through December 31, 1982. The projected savings in Missouri are $1.5 million. On June 29, 1979, the U.S. District Court of Western District of Missouri rendered a decision which enjoined HEW from making an award in the procurement. The suit was initiated by the Blue Cross Association, et. al. Among other things, the parties initiating the suit contend that the planned experiment violated existing Medicare legislation, which permits participating providers of health care services to nominate their Part A fiscal intermediary. On August 27, 1979, HEW filed an appeal with the U.S. Court of Appeals for the Eighth Circuit requesting a reversal of the lower court's decision. Oral arguments were completed two weeks ago and a decision is expected in March or April.

5. Colorado, Utah, and Wyoming (Consolidated Parts A/B)

The RFP for this procurement was released on August 2, 1979. This experiment is designed to test the potential efficiencies of merging several contractor operations in a multi-State environment and the feasibility of a common claims process for the Medicare Parts A and B programs. The projected savings in this experiment are $7,000,000. The preproposal conference on the RFP was held on September 12 and responses to the questions raised at the conference were mailed to the attendees recently. On September 14, 1979, the Blue Cross Association filed a suit with the U.S. District Court for District of Wyoming, and HEW has been enjoined from conducting this experiment. HEW has appealed to the Circuit Court of Appeals and briefs are to be filed in March.

HEALTH CARE FINANCING ADMINISTRATION

PART A-INTERMEDIARY WORKLOAD DISTRIBUTION



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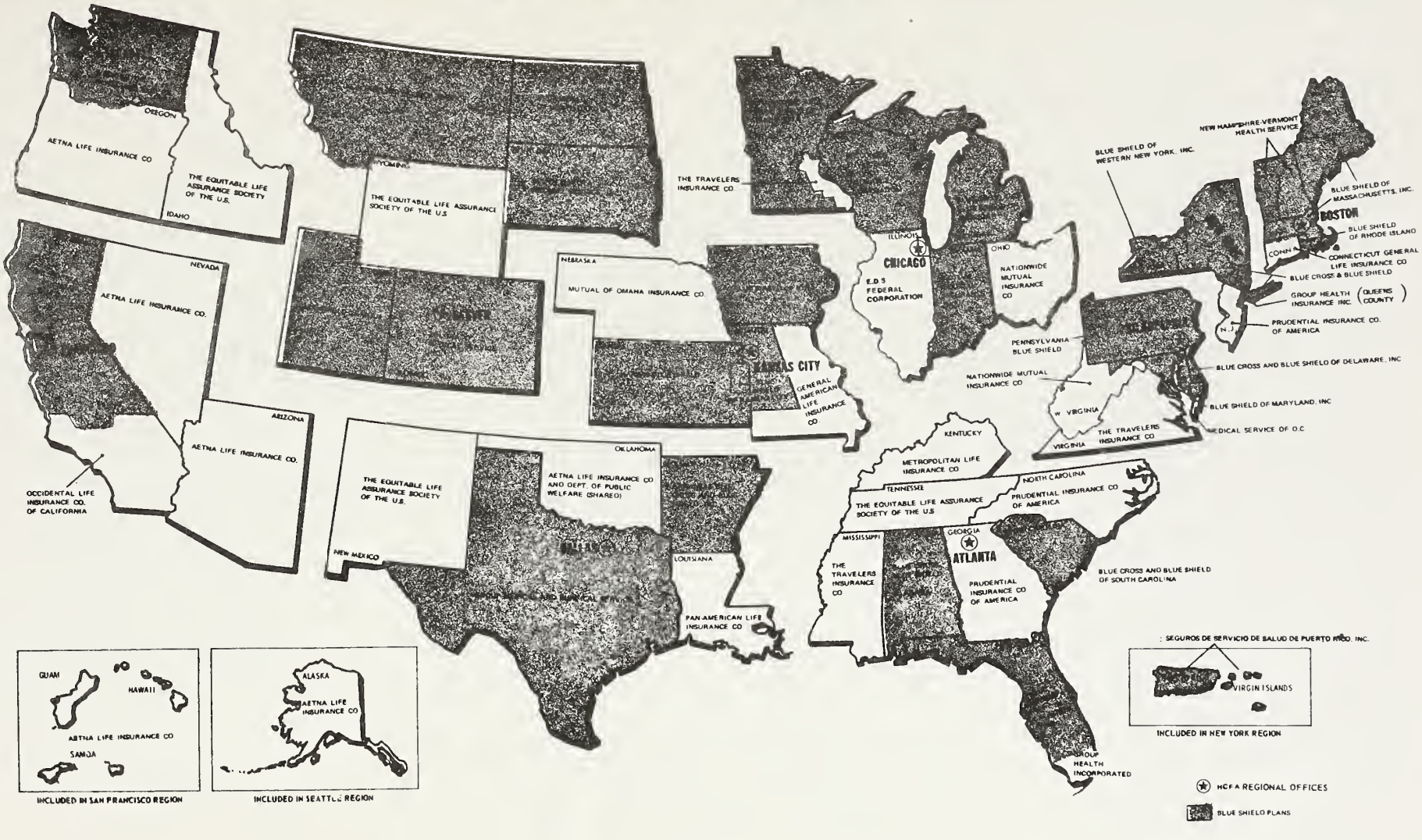
HEALTH CARE FINANCING ADMINISTRATION

'MEDICARE' PART B CARRIERS



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DISCUSSION PAPER

HCFA GOALS FOR IMPROVING CONSISTENCY, ACCURACY AND COMPARABILITY OF DIAGNOSIS AND PROCEDURE LABELING SYSTEMS

February 28, 1980

Diagnosis labeling systems for classifying diseases, conditions and illness, and codes to identify each diagnosis are vital in describing why medical services were sought or provided. Procedure labeling systems describe in scientifically accurate terms the specific medical services provided, and attach unique codes to each unique procedure.

The Health Care Financing Administration wishes to inform all parties concerned or affected by our policies related to obtaining and using diagnosis and procedure information, of our goals for improving consistency, accuracy and comparability in the labeling of these important data elements.

Diagnosis Coding (ICD-9-CM)

Substantial progress has been made since the September 14, 1978 announcement that use of ICD-9-CM was to become the required diagnosis labeling system for HEW financed programs. Efforts by a number of organizations have resulted in the establishment of ICD-9-CM as an almost universally accepted and used disease classification system in U.S. hospitals, health care financing programs and data systems.

HCFA is especially thankful for the efforts of the U.S. Public Health Service and its National Center for Health Statistics for convening the Steering Committee which provided advice and guidance to the Commission on Professional and Hospital Activities in the development of this system, and to the organizations represented on this steering committee--

American Association of Health Data Systems

American Hospital Association

American Medical Association

American Medical Record Association

Association for Health Records

Council on Clinical Classifications

WHO Center for Classification of Diseases

in North America

In March 1978, The American Hospital Association began encouraging members to introduce ICD-9-CM in hospitals by January 1979. The American Medical Records Association and the American Hospital Association undertook an active effective effort to train constituents in use of this new system. HCFA undertook a series of annoucements to State Medicaid agencies to encourage their adoption of ICD-9-CM for diagnosis labeling, issed requirements to PSROs that ICD-9-CM be used for the PSRO Management Information System and the PSRO Hospital Discharge Data Set, and instructed Medicare intermediaries to accommodate hospital conversion to ICD-9-CM and to use ICD-9-CM in any tape billing or other diagnosis labeling activity performed in their Medicare intermediary role. Since 1979, ICD-9-CM has been used in the HCFA centralized coding of sampled Medicare Part A claims. In May 1979, the

Blue Cross Association and Blue Shield Association announced that ICD-9-CM used by their members would be required for the Federal Employee Program, National Account Paid Claims and Inter-Plan Bank records.

In June, 1979, the Health Care Financing Administration and the U.S. Public Health Service National Center for Health Statistics convened the first of a series of meetings of representatives of non-Federal health industry interests to discuss the prospects for a universal procedure labeling system. The goal was to coordinate, simplify and improve the quality and utility of procedure information as was being accomplished with diagnosis labeling. At that meeting, there was a strong concensus that Volumes 1 and 2 of ICD-9-CM are suitable for universal use in diagnosis labeling. Participating organizations included:

- American Association of Health Data Systems
- American Association of PSROs
- American Hospital Association
- American Medical Association
- American Medical Record Association
- Blue Cross Association
- Blue Shield Association
- Commission on Professional and Hospital Activities
- Federation of American Hospitals
- Health Insurance Association of America
- Maryland Health Services Cost Review Commission
- Michigan Medical Services Administration
- National PSRO Council
- New Jersey State Department of Health
- New York State Department of Health
- Texas Department of Human Resources
- Public Health Service
- Health Care Financing Administration

Procedure Labeling (Modified CPT-4)

This group expressed a consensus that a universal procedure labeling system would be desirable if feasible. A series of followup meetings were held through November 1979 to further consider the feasibility of universal procedure labeling. There was general agreement that uniform procedure labeling was feasible for all settings, but concern was expressed that ample time should be provided to develop and evaluate such a system prior to its introduction.

In HCFA programs there are two major uses of procedure information. The major use of procedure information is for Medicare and Medicaid programs in the determination of reimbursement for professional fees. The second important use of procedure information is the conduct of professional standards review.

Through continued industry liaison it has been concluded that a uniform procedure labeling system could and should be developed based upon Physicians Current Procedural Terminology - 4th edition (CPT-4).

CPT-4 was chosen because:

- CPT-4 is already familiar to and used by many physicians.

- CPT-4 contains the most comprehensive listing of terminology describing medical procedures and practices.

- CPT-4's coding structure (five core digits plus two-digit modifier codes) is adaptable for procedure coding for nonphysician services.

- There are numerous third party payment programs including several State Medicaid agencies which have effectively employed CPT-4 or closely akin systems for their reimbursement needs.

- The American Medical Association has developed and implemented mechanisms for keeping the contents of CPT-4 updated to reflect changes in medical technology, and in this process, AMA considers recommendations for changes arising from various sources throughout the health sector.

- The costs of implementing a CPT-4 based system appear to be lower than the costs of adapting some other widely used system or develop a brand new system.

- The American Medical Association has indicated its willingness to come to agreement with HCFA concerning copyright and other issues associated with use of CPT-4.

This year we intend to review CPT-4 to determine what kinds of modifications are needed to make CPT-4 suitable for use in all settings. These would include labeling procedures for the preparation of medical record abstracts needed by the Professional Standards Review Organizations, as well as for use in Medicare and Medicaid reimbursement operations. Results of this effort and plans for testing and evaluating the resulting prototype will be shared with all interested parties.

HCFA intended to pursue the goal of ultimately having a common approach to procedure labeling that can effectively meet all Medicare, Medicaid and PSRO program needs for procedure information. We plan to continue to work with the Public Health Service National Center for Health Statistics, the AMA, AHA and other representatives of the health industry, in the development of a procedure labeling system which can meet all HCFA program needs for procedure information, and the common needs of other sectors of the health industry.

During the course of these developments, HCFA intends to pursue a policy which would support the preparation of Medicare, Medicaid and PSRO data systems for the eventual implementation of a procedure labeling system based upon CPT-4. In preparation for effective reimbursement applications of a CPT-4 based system, HCFA has established a technical advisory group of Medicare carrier, State Medicaid agency and Regional and Central Office staff experts. They will develop recommendations concerning appropriate terminology and coding for nonphysician services fee reimbursement, and for controls to assure that claims processing and outlays would not be disrupted or escalated after implementation. Also, arrangements have been made with the South Carolina State Medicaid agency, and South Carolina Blue Shield, the Medicare carrier, to collectively serve as a test site for application of processing and reimbursement controls with CPT-4. Once we are confident that a CPT-4 based system can be used for reimbursement purposes without adding to inflationary pressures, we intend to establish its use throughout Medicare, Medicaid, and the PSRO program.

Summary

The Health Care Financing Administration is committed to the development of improved systems for labeling procedure information. We expect that uniform procedure labeling will improve the consistency, accuracy and comparability of procedure data. We believe that such improvements will result in much more effective management of HCFA's programs, and in substantial long run reduction in the costs of information needed to operate the Medicare, Medicaid and PSRO programs. We invite the spectrum of affected sectors in the health industry to support and participate in the attainment of these goals. We hope that the developing modification of CPT-4 will become as broadly acceptable for procedure labeling, as ICD-9-CM Volumes 1 and 2 have become for diagnosis labeling. Regulatory proposals and administrative procedures to complement the attainment of these goals will be forthcoming.

Please forward any comments or recommendations on this discussion paper to:

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Please reference the title and date of discussion paper in your comments.

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